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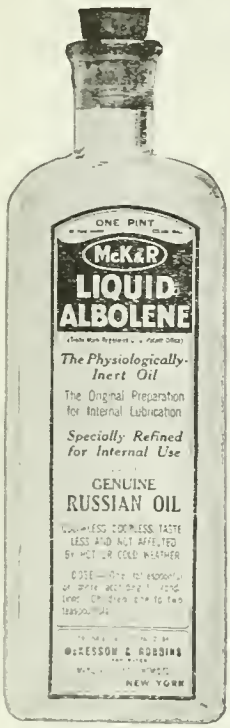

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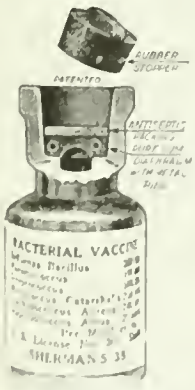

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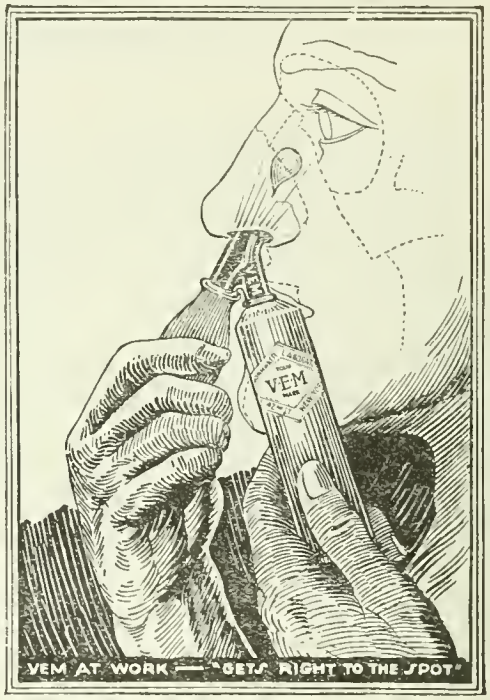

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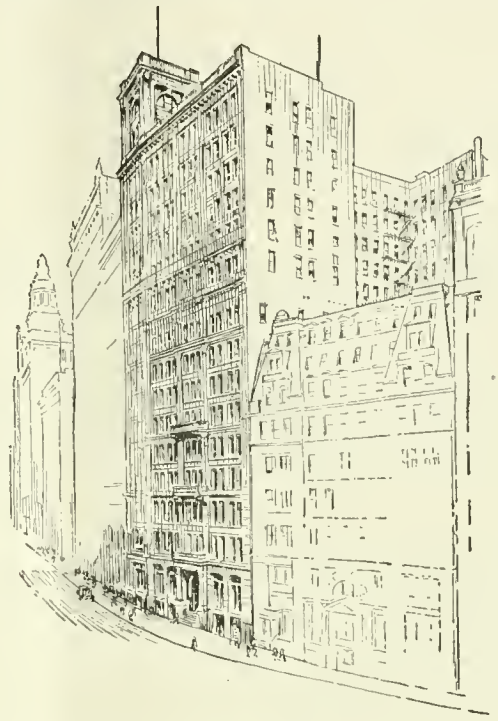

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Original Articles.

SEMINAL VESICULITIS: ITS LOCAL AND GENERAL MANIFESTATIONS.*

BY JOHN H. CUNNINGHAM, M.D., BOSTON.

IT is my belief that the medical profession, in general, knows perhaps as little about the seminal vesicles as any other organs in the body. Moreover, it has only been in recent years that the leaders in the field of genito-urinary surgery have given the diseases of these organs the attention which they deserve. Most of us have had an indefinite idea of their anatomical location and structure, that they have something to do with propagation, and some may recollect that Dr. Eugene Fuller has written much about gonorrheal focal infection in these organs, producing so-called gonorrheal rheumatism and that by removing these foci the rheumatic manifestations can be cured. Perhaps some remember that Dr. William Belfield of Chicago has likened gonorrheal infection in the seminal vesicles to gonorrheal infection in the Fallopian tubes and has called the seminal vesicle so infected the pus tube of the male, and has devised an operation to attempt to cure such seminal vesicle infection by irrigations through the vas deferens. But in general, a comprehensive understanding of the diseased seminal vesicle, the local and general manifestations dependent upon it are lacking, even among most who profess to be especially interested in the subject of genito-urinary surgery.

Naturally it is impossible to cover the whole subject of the anatomy, physiology, pathology, and the diagnosis and treatment of all diseases of the seminal vesicles at this time, and attention, therefore, will be directed only to infections, non-tubercular, chiefly gonorrheal in origin, the symptoms they produce, and the treatment which such conditions should receive.

In regard to the *clinical pathology*, an anterior urethritis, usually, but not always of gonorrheal origin, extending to the posterior urethra may infect the glandular structure of the prostate, extend up the ejaculatory ducts to the seminal vesicles and down the vas deferens to the epididymis so that through the continuity of the different organs in the genital system we may have an extension of an anterior urethritis through the whole genital tract and when an epididymitis is observed in connection with anterior urethritis it is certain that the infection has involved to some degree all the structures in its course to the epididymis.

The prostate and vesicles having once become infected, remain so over long periods of time,

* Read before the Suffolk District Medical Society, Oct. 25, 1920, and the New York Branch of the American Urological Association, Dec. 8, 1920.

because the natural avenues of escape for the products of inflammation are very small and not sufficient in size to drain the infected areas. In fact, it is questionable if the prostate or seminal vesicles once infected ever become absolutely healthy organs. Certain it is that remissions of urethral discharge and recurrent epididymitis, also certain systemic infections find their explanation in this fact. It is, therefore, the retention of infection and the products of inflammation in the prostate and seminal vesicles that result in the clinical disturbances both local and general.

The local disturbances are a urethral discharge, often with remissions, but sometimes persistent over long periods of time, often many years, which discharge, if not recognized as originating from the infected prostate and seminal vesicles, is generally treated as an anterior infection by internal medication and anterior injection without beneficial results. This is the common observation of the genito-urinary specialist, who so often gets the patient after both the patient and the uninformed doctor have been discouraged by the lack of progress.

Investigation of the prostate and seminal vesicles by rectal examination and by a microscopical examination of the fluid expressed from these organs locates the lesions in these structures if they are present, and in the absence of lesions in the anterior urethra, which fact is established by the microscopical examination of any urethral secretions; by calibration and endoscopy, the treatment of the prostate and seminal vesicle lesions is begun by prostatic and vesicle massage, installations or irrigations, which treatment will have to be pursued for months in most instances, and even then a cure may not be attained.

There is a group of patients from whom infectious material cannot be removed from the seminal vesicles no matter how long appropriate palliative treatment is carried out, for the reason that certain infected areas cannot be kept sufficiently open to drain through the natural channels, an explanation of which will be found by studying the anatomy of the seminal vesicles which shows their structure to be one of multiple branches and numerous diverticulae. This group of patients to be made free from a urethral discharge and infection must have the seminal vesicles removed or completely drained to affect a cure. In other words, it should be thoroughly appreciated, especially in view of the present campaign against venereal diseases by the Public Health Service, that there is a group of male individuals with infected seminal vesicles and prostate whose only symptom is a persistent or intermittent urethral discharge. I think it is fair to say that no attempt is made by most doctors who are willing to treat such patients to locate these lesions by making an examination of the anterior urethra by a microscopical examination of the urethral discharge; calibration of the anterior urethra for stricture, or to prove or disprove their presence by endoscopy, and moreover, the knowledge of the condition of the prostate and seminal vesicles which may be gained by massage of these organs through the rectum, collecting the material so expressed and the microscopic examination of the collected material, is too seldom done. Unless one appreciates the methods of locating the lesions as just mentioned, the individual with a urethral discharge is usually treated by internal medication and anterior injections without benefit. To carry the matter of treatment a step further, those who have much to do with venereal diseases recognize and employ the methods of diagnosis just referred to and treat the patient with seminal vesicle and prostatic infection by massage of these organs, thereby emptying them of the products of inflammation, following the massage by irrigations or installations, giving careful directions regarding a non-irritating diet and the necessity for large ingestions of water. They realize further that progress is slow, and months of time are necessary to affect a cure under the most appropriate treatment. They recognize also that recurrences of discharge are prone to occur even after all symptoms have been absent for months or even years. They also appreciate the fact that there is a small group of patients with infection of the prostate and seminal vesicles, who, no matter how long or intelligently treated, cannot be freed from the discharge of pus from the lesions located in the prostate and seminal vesicles. It was for this group of patients that Dr. Belfield devised and practised the procedure of irrigating the diseased seminal vesicle by opening the vas deferens through a scrotal incision and injecting an antiseptic solution up the vas deferens and through the diseased seminal vesicles with the idea of cleansing and killing the infection within it. This procedure, based upon a thoroughly sound conception has

not proved to be all that may be desired because it is seldom that a single injection produces a cure and repeated injections are not always possible because of the difficulty of keeping the incision in the vas deferens open, and because, furthermore, the solution injected may not enter all the infected areas. That there are some patients cured by this method of treatment is unquestionable; but on the whole the results are not satisfactory. With these patients where failure results from this procedure nothing short of thorough surgical drainage or the extirpation of the diseased organs will result in a cure.

I have found it necessary to perform such an operation on forty patients who had received local treatment over periods of months or years; the areas of infection being persistently active, or quiescent at times, to be followed by acute exacerbations without known cause in many, or after the lowering of the general resistance by overwork or some acute illness such as influenza.

The operation should be undertaken only after many months of conscientious local treatment and it is evident that a cure of the lesions cannot be attained by any treatment other than the removal of the lesions surgically. If the operation is undertaken, under the circumstances indicating it, as just mentioned, the prostate should be drained also, for it has been definitely proved that an infection may be expected to co-exist within it, to some degree at least, when the seminal vesicles are infected.

As a result of the operation the majority of patients are free from any urethral discharge before the operative wound is healed and those who require any further treatment have been those patients with associated urethral mucous membrane changes, which changes, whether dependent or independent of the prostate and seminal vesicle infection, cannot be cured when constantly bathed in the products of inflammation from persisting lesions in these organs.

I wish to briefly touch upon another local manifestation dependent upon infection in the seminal vesicles and prostate, namely perineal and genital pain, which pain is sometimes referred to the rectum and accentuated by defecation. This pain, as far as I can judge, is indefinite in character, sometimes severe and usually observed in neurasthenic individuals; and associated with sexual disturbances, painful erections, frequent nocturnal emissions and sometimes the semen ejaculated or collected by massage is mixed with blood. These patients often without any urethral discharge usually give a history of previous urethritis, but in some instances, such an infection has been denied. When the examination of such patients shows the absence of rectal and bladder disease and the presence of palpable changes in the prostate and vesicles associated with abnormal elements in the fluid expressed from these organs, the pain may be ascribed to disease in these structures. Dr. Eugene Fuller, the father of seminal vesicle drainage, insists that such lesions in the seminal vesicles may account for these indefinite pains and produces the condition commonly called sexual neurasthenia.

There are so many factors entering into the complex picture of sexual neurasthenia that I personally cannot accept his dictum without reserve, and believe that changes in the verumontanum, the so-called sexual heart, if present, should at least receive treatment, and local treatment of the seminal vesicles tried before subjecting such patients to seminal vesiculectomy as advocated by Dr. Fuller. In support of his contention, however, it should be stated that those patients upon whom I have operated for other indications, but with the type of pain referred to, have usually been improved in this respect also, and those with what might be called neurasthenia have improved as a rule. I have been inclined, however, to ascribe such mental improvement not entirely to the removal of the disease in the seminal vesicles but rather to the mental relief incident to worry because of the persistent urethral discharge, the necessity for constant medical care and the multiplicity of social factors which influence the mental attitude of one with a secret disease.

In regard to the *general manifestations* dependent upon infection in the seminal vesicles and prostate, aside from those just referred to as neurasthenia, and which may or may not be so considered, I wish to refer to the metastatic disturbances particularly the arthritic manifestations.

It has become a well-established fact that foci of infection may, through some peculiar selective action, involve other structures, particularly the synovial membranes and bones, so that today the profession in general, look for some focus of infection to explain so-called rheumatic manifestations. The teeth and tonsils

have attracted the most attention as the sites of such foci; in fact, the profession, in general, think too seldom of any other possible nidus of infection; and often with only questionable lesions in these structures, teeth or tonsils or both are being sacrificed without a thorough differential diagnosis; often with the good fortune of a brilliant cure of the metastatic arthritis when the interpretation is correct; but sometimes without this good fortune because the foci are located elsewhere. Not infrequently such foci are in the deep genital structures and occasionally in the digestive or urinary tract, all of which systems must be considered in the differential diagnosis in any instance where there is not an obvious focus of infection in the teeth, tonsils or head sinuses to explain the arthritis.

It is of interest in this connection to note the fact that the first conception of curing arthritis by the surgical removal of foci of infection was brought forward by Dr. Eugene Fuller of New York in a publication in the *Annals of Surgery*, June, 1905, entitled "The Relation of Gonorrheal Rheumatism to Seminal Vesiculitis and Its Cure by Seminal Vesiculotomy. What Dr. Fuller pointed out at that time and in his later publications, also the publications of others in this connection have not been generally appreciated; and today, when the principle of focal infection as an explanation of infectious arthritis has been generally accepted, foci of infection to explain metastatic arthritis are commonly thought of; the teeth and tonsils alone, being considered by most, and the possibility of foci in the prostate and seminal vesicles as the possible cause of the arthritis is usually the least thought of in this connection. It is my desire to emphasize the importance of including such possible sites of infection in the differential diagnosis of infectious arthritis for I have seen too many patients who have had their teeth and tonsils removed without benefit to their arthritis because the foci of infection were in the prostate and seminal vesicles.

I do not wish to convey the impression that the removal of foci of infection in teeth and tonsils are not followed by brilliant results, or that gonorrheal arthritis is usually an obscure disease and not generally recognized; but I do wish to convey the idea that gonorrheal arthritis may be dependent upon a gonorrheal infection of so long standing, and the urethral discharge so slight or even absent, that unless the fact of a previous urethral infection is elicited in the history and a special examination made to determine the condition of the prostate and seminal vesicles, that foci of infection in these organs as the cause of an obscure arthritis may be overlooked.

The common course of events is that a gonorrheal arthritis will develop while the patient still has a more or less active urethral discharge from lesions in the prostate and seminal vesicles, yet I have observed patients in whom chronic prostatitis and seminal vesiculitis, of gonorrheal origin, has persisted with or without remissions of urethral discharge over long periods of time, and the onset of the arthritic manifestations had no other possible explanation except from the foci of infection in these deep genital structures. I have also observed patients with a chronic prostatis and vesiculitis and associated arthritis who denied any urethral infection and who have no urethral discharge; but the material expressed from the prostate and seminal vesicles has shown evidence of existing infection in these organs. I am convinced that all infections in the prostate and seminal vesicles are not gonorrheal in origin. It it interesting to note that Billings has pointed out the relationship of chronic staphylococcus infection of the seminal vesicles to arthritis deformans and that infection in these organs, other than by the gonococcus, may produce systemic disease.

Other metastatic manifestations that should be mentioned in connection with foci of infection in the deep genital organs are gonorrheal iritis and synovitis, particularly of the tendo Achilles, which complication, like metastatic gonorrheal arthritis, require that the foci of infection be cured to relieve these complications.

The method of establishing the presence of foci of infection in the prostate and seminal vesicles, as already alluded to, is that the history should, as a rule, disclose an existing or previously existing urethral discharge and the material expressed from the prostate and seminal vesicles by rectal massage, and collected in a clean dish must show, by microscopical examination, clumped pus and desquamated cells from the prostate and vesicles, or both. The absence of the gonococcus is not important, in fact other organisms are more frequently found. If the gonococcus is present it is not usually

found within pus cells unless the infection is recent or particularly active.

The pathological changes noted by rectal palpation are in the form of a boggy enlargement of the prostate with or without nodules, and enlargement of the seminal vesicles with thickening of their walls, or the vesicles may not be detected because of the plastic exudate of a perivesiculitis. It is, however, the microscopical examination of the secretions expressed from these organs that gives the true evidence; just as the examination of the urine does with a palpable kidney.

The *diagnosis* therefore depends upon the history of urethral infection, the demonstration of pathological changes in the prostate and seminal vesicles by rectal palpation and above all, the presence of clumped pus in the microscopical examination of the secretions expressed from these organs. The complement fixation test for gonorrhea is of value and should always be employed in determining whether or not an arthritis condition is gonorrheal in origin. It is the contention of some authorities that the administration of gonorrheal vaccine may render an otherwise positive reaction negative; which fact must be borne in mind.

The *treatment* of foci infection in the prostate and seminal vesicles associated with metastatic manifestations does not differ from that of such infections without the metastatic disturbances, except for the employment of gonorrheal vaccines, and certain orthopedic features when indicated to relieve local suffering. The cure, of course, depends upon the destruction of the focal infection in the deep genital organs. This may be accomplished by non-operative treatment, as already mentioned, in the form of prostatic and vesicle massage, irrigations and installations, vaccines and general treatment Such palliative treatment is effective in about 10 per cent. of patients with real gonorrheal arthritis. In the mild cases non-operative treatment suffices to relieve all of the most acute symptoms, improvement is slow, recurrences are prone to occur and the individual must be considered to be infectious until proven otherwise.

If palliative treatment does not show satisfactory progress after a trial of weeks or months, or if the disturbances progress, the process may be arrested by the surgical removal of the foci of infection.

There is no operation for a chronic condition with which I am familiar, which gives more brilliant results. With the removal of the foci of infection, the pain has disappeared from the affected joints, often at the time of the ether recovery; and large, swollen joints have become normal in appearance, or nearly so, and painless, voluntary motion is often possible within twenty-four to forty-eight hours after operation. The periarticular swellings disappear much more rapidly than those which are intra-articular, and when destruction in cartilage and changes in bone have taken place, as may be expected if the articular lesions are of long standing, a considerable period of time and appropriate accessory treatment are necessary to repair such defects. Nevertheless the activity of the process is arrested with the removal of the foci of infection and the repair process may begin.

The indication for operative treatment is a failure to produce a cure by palliative measures.

I wish to refer to certain features connected with the operative results about which I have often been asked. Those who have observed the course of these patients admit the brilliancy of the results, but naturally wonder what influence the operation has upon the sexual life.

I have performed the operation of seminal vesiculectomy or vesiculotomy with prostatotomy on about two hundred patients and have yet to learn of a patient who has become impotent. That they are sterile, I believe, although I have had a few patients who insisted to the contrary. In connection with the matter of sterility, it is probable that a large percentage of patients with advanced seminal vesiculitis and prostatitis are sterile because of the lesions and the operation cannot add to the damage already done. Whatever the known truth of this feature may be, it is certain that most patients with seminal vesiculitis and prostatitis must be considered infectious to others; and moreover those patients with real gonorrheal arthritis, that is so severe as to require operation, think little of sexual life and, being infectious, should not be permitted to if they did. Most are chronic invalids and when given the choice of being made useful individuals at the expense of reproduction (which they have probably lost anyway from the lesions), there has never been any hesitation in accepting the chances of cure by operation.

Another point which has been raised is the question of relapses. I have seen but two patients with returning symptoms and both of these patients had their symptoms return only after acquiring a new gonorrhea. One of these patients had played professional baseball for six years following his operation, having been out of the game two years previously on account of his gonorrheal arthritis. His recurrences were relatively slight and subsided with the disappearance of the new gonorrhea which was an anterior and posterior infection.

The other patient was a chauffeur who had periosteal spurs removed from both os calces at the time his vesicles and prostate were attacked. This patient was known to have flat foot at the time of operation. Three years after the operation he acquired a new gonorrhea involving the anterior and posterior urethra. He had a tenio synovitis of both tendo Achilles which disappeared with the activity of the new infection.

In considering the operative results it must be borne in mind that those patients who have changes in intra-articular cartilage such as destruction or ulceration and bone changes, atrophy or periosteal hyperplasia, must have appropriate accessory treatment to repair such defects. What the operation does in this group of patients is to remove the foci of infection which causes these changes that repair may be accomplished. The results in those patients who have the foci of infection removed before destructive metastatic lesions develop, are of course, the most brilliant.

In performing the operation both the seminal vesicles and the prostate should be attacked, for there is abundant clinical and pathological evidence to show that infection may be expected to exist in both, and clinically I have observed patients improved only but not cured by the mistake of the operator to destroy only the lesions in the seminal vesicles. A second operation, draining the prostate, has resulted in a cure. Likewise it is necessary in attacking the seminal vesicles that every focus of infection be destroyed. For that reason multiple punctures sometimes fail in their purpose. When possible it is probably safer to extirpate the vesicles, or if not to remove the entire posterior surface and sterilize every portion with carbolic acid and alcohol. I have done a secondary operation upon a patient who had the seminal vesicles drained by puncture and a prostatotomy performed with only partial relief, and a subsequent removal of the vesicles resulted in a cure.

I am convinced that nothing short of a complete removal of all foci of infection will give the desired result; and while to accomplish this it may be necessary to thoroughly destroy the vesicles, the prostate needs only free drainage by multiple incisions. Patients who have been operated upon without benefit are those in whom the operation is incomplete.

In Conclusion.

1. I wish to suggest that patients with a persistent urethral discharge be examined to determine the condition of the prostate and seminal vesicles as well as the condition of the anterior urethra.

2. That there is a group of patients with infection in the seminal vesicles and prostate which cannot be cured of a urethral discharge except by destroying such lesions by surgical measures.

3. That the possibility of foci of infection in the seminal vesicles and prostate be included in the differential diagnosis of infectious arthritis.

4. That patients with such foci of infection and metastatic disturbances be subjected to surgical drainage of such foci of infection if improvement is not satisfactory by non-operative treatment.

PRIMARY DISEASE OF THE PELVIC LYMPHATIC GLANDS. AN UNRECOGNIZED GYNECOLOGICAL CONDITION

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ALTHOUGH no little study has been given to the lymphatic glands of the pelvis from both the anatomical and clinical standpoints, such investigations have been practically limited to the consideration of these glands in malignant disease of the uterus or other pelvic organs. The possibility of non-malignant disease of these glands, as well as that of primary malignant, lymphatic disease seems to have been overlooked. The occurrence of three cases of enlargement of the pelvic glands giving rise to striking clinical

manifestations during a two months' service in the gynecological ward at the Boston City Hospital has led the writer to believe that pelvic masses consisting of such glandular enlargement must be of not infrequent occurrence although but seldom recognized. The term primary disease of the pelvic lymphatic glands is, perhaps, somewhat inaccurate inasmuch as with the sole exception of lymphosarcoma or Hodgkin's disease, involvement of any part of the lymphatic tract must be secondary to a process in some other organ or tissue. I have selected the title, however, to differentiate those cases in which the enlargement of the glands in itself gives rise to important clinical manifestations, from those in which the enlargement of the glands is solely a measure of the extent of a malignant process in another organ.

ANATOMICAL.

The lymphatic vessels and nodes of the pelvis have been carefully studied by numerous anatomists. Their arrangement is quite simple. The lymphatic vessels follow in general the distribution of the various branches of the external and internal iliac arteries.

The glands are arranged in five groups. These are the lumbar, the external iliac, the internal iliac, the sacral, and the inguinal glands. The lumbar glands lie on either side of the aorta and receive all the lymphatics from the pelvis and lower extremities. The external and internal iliac glands lie in chains along the respective arteries of the same name. The sacral glands lie in front of the sacrum just below the bifurcation of the aorta, and the inguinal glands lie in front of the superficial fascia over Poupart's ligament and in Scarpa's triangle.

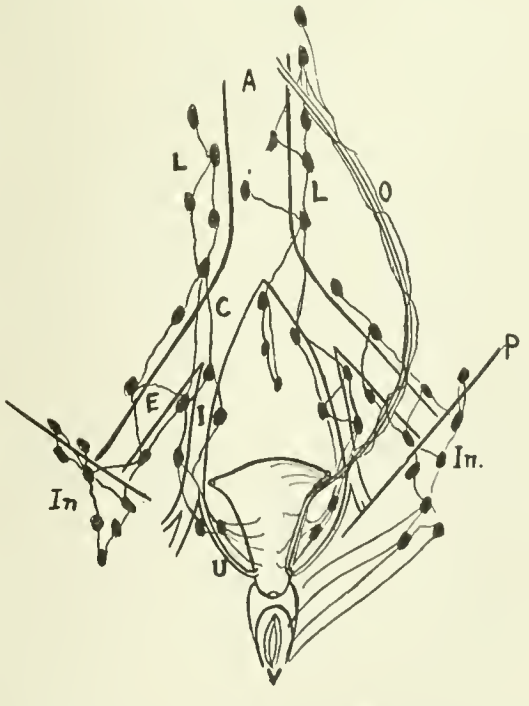
The inguinal glands receive the lymphatics from the vulva and the superficial tissues of the thigh and groin. They are drained in turn by efferent vessels which pass beneath Poupart's ligament to the external iliac glands. The external iliac glands in their turn drain into the lumbar glands.

The internal iliac glands receive the lymphatics from the cervix and the lower part of the body of the uterus. They, too, drain into the lumbar glands. The lymphatics from the fundus uteri, the Fallopian tubes, the ovaries and the upper part of the broad ligaments follow the course of the ovarian artery upward to either side of the aorta where they empty into the lumbar glands.

The lumbar glands, after receiving the lymphatics from the external and internal iliac glands, the sacral glands, and the lymphatics accompanying the ovarian artery, thus draining the pelvis and entire lower extremities, empty into a few large trunks which unite with the lacteals to form the thoracic duct.

Two more anatomical relationships of these glands are important because of the clinical manifestations resulting from their disease or enlargement. The first of these is their relationship to the psoas muscle. Both the external and internal iliac glands and the lumbar glands are in close relationship to this muscle. This is important clinically because in two of the cases to be reported psoas spasm was a prominent symptom.

The other important structure in relation with these glands is the ureter. The ureter crosses over the external iliac artery just below the bifurcation of the common iliac and passes downward and forward about midway between the external and internal iliac arteries, following somewhat the course of the uterine artery which later crosses over it just before the ureter enters the bladder. Both the external and internal iliac glands, but more especially the latter, are therefore in close relationship to the



Lymphatics of the Pelvis (Diagrammatic)

A, aorta; *C*, common iliac artery; *E*, ext. iliac artery and glands; *I*, int. iliac artery and glands; *L*, lumbar glands, *O*, ovarian artery and lymphatics; *In*, inguinal glands; *P*, Poupart's ligament; *U*, uterine artery; *V*, vulva.

ureter, and marked enlargement of these glands may compress the ureter and cause obstruction, as occurred in the first of the cases to be reported.

CLINICAL.

Case Reports.

CASE 1. Boston City Hospital No. 404528. Age, 34. Married. Four normal labors, two miscarriages. Came to Out-Patient Department on June 20, 1920, complaining of pain in the left abdomen of a few days' duration. Examination showed marked tenderness over left kidney and along course of left ureter. The urine was negative, both chemically and microscopically. By vaginal examination a mass on the left side, well out toward the pelvic brim and not connected with the uterus was found. The uterus was in normal position. The right side of the pelvis was normal. The temperature and pulse were normal. General physical examination was negative except for a slightly cachetic appearance.

The patient was referred into the hospital for observation and the following day a cystoscopy was done. The bladder mucosa was normal and both ureteric orifices were normal, but on catheterization of the left ureter, obstruction was met with, about three-fourth to an inch from the bladder. This was confirmed by the use of several catheters of different sizes. On the right side the catheter was easily passed to the kidney pelvis. Diagnosis of a pelvic mass of unknown character not arising from the uterus or uterine appendages and causing obstruction of the ureter was made.

Operation June 25, 1920. Median incision below umbilicus. Uterus and appendages found normal. Over left pelvic brim beneath peritoneum, an irregular nodular mass was found. The peritoneum was incised and the mass which was dissected out with much difficulty was found to consist of greatly enlarged external and internal iliac lymph glands. The mass had compressed the external iliac artery to about one-half its usual size. The glands were closely adherent to the ureter, from which they were separated with care and the ureter freed from compression. The patient made an uninterrupted recovery, the abdominal pain cleared up at once, and she was discharged from the hospital in two and one-half weeks.

Pathological examination of the glandular mass by Dr. Frank B. Mallory showed changes identical with those of Hodgkin's disease. Following the receipt of the pathological report, a second physical examination was done and a careful search made for enlarged lymph nodes in other parts of the body which, it was thought might have been overlooked in the first examination, but absolutely none were found. A blood examination was done by Dr. Ralph C. Larrabee with the following result: haemaglobin, 72.8%; red corpuscles, 3,710,000; white corpuscles, 11,600; color index, .98. Differential count: polymorphonuclears, 78½%; eosinophiles, 0; mast cells, 0; large lymphocytes, 15½%; small lymphocytes, 2½%; large mononuclears, 0; transitional, 3½%. No achromia. Moderate variation in size, prevailing size probably normal. No large oval cells. No fragmented cells. Shape of red cells normal. Platelets somewhat diminished.

CASE 2. B. C. H. No. 404999. Age, 28. Single. Entered hospital June 30, 1920. For one week intense pain in the left groin, and lameness. Examination showed marked tenderness over the left iliac fossa without rigidity. There was a psoas spasm causing about 15 degrees flexion of the thigh. Complete extension was impossible. A few slightly enlarged and very tender inguinal glands were palpable on the left, which were apparently secondary to a small area of pustular eczema on the left labium majus. Vaginal examination showed nothing abnormal except marked tenderness over the left pelvic region. Temperature, 102.8; pulse, 100; white count, 9,000; haemaglobin, 85%. X-ray examination of the pelvis negative. The patient was put to bed, ice applied to the left iliac regions and measures of cleanliness instituted to the eczematous region. The temperature gradually fell to normal, and the iliac tenderness and psoas spasm disappeared. July 26 vaginal examination disclosed a mass along the pelvic brim very similar to the mass described in the previous case, obviously not connected with the uterus or appendages. All symptoms had now disappeared so the patient was discharged without further treatment. There can be no doubt, however, that in this case infection was carried from the eczematous area on the vulval to the inguinal glands and from these to the iliac glands, the inflammation of which latter resulted in the iliac tenderness and psoas spasm which were the most striking symptoms the patient presented.

CASE 3. B. C. H. No. 403,383. Colored. Age, 38. Married. One child five years old. On April 8, 1919, uterus and both tubes and ovaries had been removed for myoma by supravaginal hysterectomy. She was well after this operation until December, 1919, when, following a supposed attack of influenza, she developed pain in the right lower quadrant of the abdomen and lameness of the right leg. Entered hospital May 11, 1920. Right thigh in 15 degrees flexion. Complete extension impossible. Temperature normal. Pulse normal. White count, 11,200. Haemaglobin 75%. X-ray of pelvis negative. Vaginal examination showed a mass closely connected with the pelvic wall on the right rising somewhat above Poupart's ligament and not connected with the cervical stump, which was still present. The diagnosis was made of psoas abscess of unknown cause.

Operation June 2, 1920. Incision one inch above and parallel to right Poupart's ligament, carried down to subperitoneal layer. The peritoneum was then carefully dissected backward and an abscess containing several ounces of odorless pus, occupying the general region of the iliac vessels and anterior to the psoas muscle, was drained extraperitoneally. No direct communication with the cervical stump was made out.

Following operation the psoas spasm disappeared almost immediately, the sinus healed rapidly and the patient was discharged well June 22, 1920. There may be in this case, some doubt as to this abscess having its origin in the pelvic lymphatic glands. After careful reflection, however, I am convinced that this is a companion case to the first two for the following reasons: first, the location of the mass was similar to that in the other two cases; second, because the symptoms of iliac pain and psoas spasm closely resembled those in Case 2; third, the uterus and appendages having been removed, the pelvic lymph glands would be practically the only remaining organs or tissues which could be the seat of suppuration. The portal of entry may have been the cervical canal, the infection having travelled by the cervical lymphatics to the iliac glands; or the infection may have been blood borne. Many queer local suppurations have been observed in remote parts of the body following influenza and this abscess may have been one of them, if we admit the accuracy of the diagnosis of influenza in this patient.

DEDUCTIONS.

While these cases are too few in number from which to draw final conclusions, they present certain very suggestive points. It is definitely proven by the existence of two undoubted cases and one probable case that such a thing as primary disease of the pelvic lymphatic glands producing striking, if not characteristic symptoms, does exist. A search of a dozen or fifteen recent textbooks of gynecology fails to reveal any mention of such a possibility. Therefore it seems worth while to analyze these cases from the standpoint of a study of the symptom-complex to be expected from this condition.

Tumor. A mass in the pelvis close to the pelvic brim and definitely not connected with the uterus or its appendages was present in all three cases.

Pain. Pain was present in all three cases. In two it was localized in the right iliac fossa. In Case 1 it was localized along the course of the ureter and in the kidney region and was due to occlusion of the ureter by pressure of the glandular mass from without.

Psoas Spasm. Psoas spasm was present in two of the three cases and must be regarded as quite an important symptom. Of course an x-ray of the spine is necessary to rule out the mass and contracture due to psoas abscess from spinal caries.

White Count. The white count in all these cases, even the one with abscess, ranged between 9,000 and 11,600. Further observations may or may not reveal higher white counts in more virulent infections. The white count, obviously, must be influenced in great part by the particular organism concerned as well as the resistance of the patient.

In reference to the case of Hodgkin's disease primary in the pelvis glands, this cause of enlargement as well as the ureteral compression resulting must be looked upon as a rare and unusual occurrence to be seldom met with but to be borne in mind as a possibility. The writer believes that further investigation will show that many of the pus masses not uncommonly met with in puerperal sepsis extending upward along the psoas muscle and pointing above Poupart's ligament consist of suppurating iliac glands, as the lymphatics from the body of the uterus drain directly into these glands and form the most probable path for infection to travel.

TREATMENT.

The treatment of disease of the pelvic lymph glands is the same as that of enlarged or diseased glands elsewhere in the body. A mass definitely containing pus should be opened. Where the glands are acutely inflamed but suppuration has not taken place, treatment should be restricted to rest and cold applications. Where enlargement of the glands is sufficient to cause pressure on important organs as in Case 1, and does not rapidly subside under palliative treatment, excision will be indicated.

CONCLUSIONS.

Primary enlargement of the pelvic lymph glands is a distinct clinical entity not generally recognized in gynecology.

The diagnosis is to be based upon a pelvic mass definitely not connected with the uterus or its appendages, giving rise to the following symptoms: pain and tenderness referred to the iliac fossa of the affected side, with or without elevation of temperature, and with or without psoas spasm on the affected side. The white count in the few cases so far observed has been only slightly elevated.

FASCIA USED TO MOBILIZE A STIFF KNEE RESULTING FROM GUN SHOT WOUND.

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History.

PATIENT, a boy 18 years of age. On October 12, 1915, the patient had planned to go hunting pheasants with his chum. In an accidental way his chum's shot gun was discharged and (in the patient's own words) "blew off one-half of my knee-cap and the charge entered the center of the knee, eating off the large tendon in front. It took off the outside, just leaving the hamstrings. While my chum was taking me back to the farm house where we spent the night before, I learned a little more about knee-joints. I noticed a lot of little fine threads that seemed to be a little mixed up. I was also surprised to see how the bullets went through the bone, having cut off one-third of the knee-cap and shattered the side of the joint. We arrived at the farm house and called the local doctor and at 10 o'clock I was at the Waltham Hospital."

At the Waltham Hospital the patient was etherized and operated upon by Dr. Stiles of Waltham. Dr. Stiles states the patient was very exsanguinated and weak. Ether was given and he made a repair of the patellar tendon as well as possible and at that time, Dr. Stiles states, a good deal of tissue was lost. As good a repair was done as possible and wicks placed in the knee. The patient again describes his condition: "Until five days later they had little hope of saving the leg as the knee was, of course, blood poisoned. Then they stated that they could save the leg but that it would be of little value. Amputation was suggested, but refused."

About two weeks later the writer was called at the Waltham Hospital in consultation with Dr. Stiles. The knee presented a large, swollen, red appearance, a wick coming out just below at the outer and lower border of the patella, the patient still having typical, fluctuating septic temperature. The patient himself presented a very much depressed, anemic and thin appearance. The wound was discharging pus, but temperature not very high.

The writer advised conservative treatment on general surgical principles, also an injection of anti-tetanus vaccine. The patient remained at the hospital six weeks, was released with a discharging sinus in the knee which at the expiration of four months healed up. Through this period the patient had baking and massage by his own local physician. The writer saw the patient a second time on April 15, 1916, or about six months after the injury. At that time the physical examination showed the young man had improved a little in his physical appearance, but not a great deal: still thin, anemic and careworn in appearance.

The mother states that during the past month he had been becoming depressed and, as she describes it, going down hill. Examination of the knee showed a large scar at the outer aspect of the joint. The whole outer portion of the knee-joint, for an area as big as the palm of the hand, seemed adherent. The patient's story at this time was that the knee was constantly paining him and that he was afraid to walk because any little thing that he hit, such as a pebble, or if he stubbed his toe, made him have pain enough to almost faint. The writer's examination showed less than five degrees motion, very painful, rather firm resistance, more than could be accounted for by active resistance. X-ray was asked for.

FIG. 1.

X-ray, as can be seen, shows knee-joint with thirteen bullets in it, a portion of the lower end of the patella gone and distinct irregularity

in the articulating portion of the external condyle of the femur. The patient returned in one week. In view of the fact of the large portion of tissue lost and the great amount of pain, the writer advised permission for excision, providing an arthroplasty would not seem advisable. Patient stated he would rather have a stiff knee he could use rather than the one he had.

Fig. 2.

April 24 the patient was given complete anesthesia, operated upon, and lineal incision was made on the external portion of the knee carried straight down. The entire skin fascia and capsule were adherent, as well as patella. All adherent tissue was lifted up from the bone and the joint exposed. A portion of the articulating surface of the femur that was destroyed could plainly be seen. The problem was what to do towards replacing the destroyed portion of the capsule. The writer felt that with such good joint surfaces and in view of the fact that an excision of the knee could be done any time later, if necessary, an arthroplasty should be tried. The right thigh, which had previously been prepared for such an exigency, was exposed and incision made about eight inches long and a piece of fascialata about five inches long removed. This was placed in salt solution; and all the adherent portion of the capsule and the tibia and femur, together with patella, being freed also, this fascia was placed with the smooth surface in contact with the bone, done as posteriorly as could be done and sutured; also the upper portion sutured to the edge of the patella and the wound closed. Motion was started on the fourth day by placing the limb on an adjustable knee splint which the writer used and described in the *American Journal of Orthopedic Surgery*.

The old scar gave a little trouble breaking down but in spite of that the writer gave the leg a small amount of motion each day. At the end of six weeks the writer gave the patient a little ether as it seemed that there was a certain amount of contraction of the quadriceps tendon; which under an anesthetic revealed itself plainly.

The stretching of this tendon done, the patient stayed in the hospital one week again and forcible passive motion was given with active motion and, in the words of the patient, received in a letter December 9, 1916: "In just 10 weeks after the operation I went back to work in the machine shop with about 75° motion. I have not lost a day's work since, with over 90° motion which I now have, with no pain. I am sure I have something to be thankful for."

Fig. 3.

A Whitman plate was placed on the left foot because the foot was markedly pronated, and the patient had some pain in the inner aspect of the joint; also a split knee-cap reënforced with leather. The patient now runs, walks up

stairs, and in fact has practically no disability except a small amount of crepitation in the knee-joint on flexion. The picture shows the incision which on account of the contracture seems irregular. The light scar tissue can be seen, also the two spots below are more reddened.

FIG. 4.

The second picture shows the knee in flexion, that is, active flexion. It might be stated that it was the earnest request of the mother that one bullet should be removed because there were thirteen. The writer made no great attempt toward prolonging the operation for such bullet, on account of the patient's poor condition, but, fortunately, one presented itself near the surface and was plucked out.

This paper was read and the case shown at the Boston Orthopedic Club in December, 1916, at which time he demonstrated his ability in walking and his strength in extension from the flexed position, and again, before the same club, in December, 1919, four years after the injury, at which time, for all intents and purposes, the knee was as useful as the other one. It was practically normal in flexion and had much power in extension — on the whole, a very useful joint.

This paper is presented for the purpose of demonstrating the advisability, sometimes, of using a conservative operation before resorting to a radical procedure, as in this case, a patching up, rather than an excision of the knee.

DEFECTIVE DELINQUENTS IN THE ARMY OF OCCUPATION OF THE AMERICAN FORCES IN GERMANY. HOW THEY ARE TREATED IN THE DISCIPLINARY SCHOOL.

BY LT.-COL. L. VERNON BRIGGS, M.R.C., U. S. ARMY.
(Late Division Psychiatrist, Headquerters Second Division, Germany.)

DURING the war with Germany, there were in the American Forces many defective delinquents, who were not of low enough mentality to be rejected but who proved to be incorrigible, and who were a source of a great deal of trouble to their commanding officers. Many of them were repeatedly tried for petty offences, the most common of which was absence without leave, although charges of petty thieving and assault were not infrequent.

When this type of delinquent was absent without leave he got into all sorts of trouble; their absence was usually outside of the area, and they maintained themselves by begging, borrowing and living with dissolute women; or some times French families, usually poor themselves, would listen to their hard-luck stories and take them in because they were soldiers. Fully 75% of them came back diseased.

When these men were returned to their organizations for trial after being picked up by the military police, they were usually in a run-down condition, and discipline, however severe, seemed to have little effect upon them. Their clothing was generally tattered and torn and very dirty, and if they had been long absent, it was often filled with vermin. These old clothes were sterilized and then given back in their ragged condition to the men, or, if they were destroyed the delinquent was given any old cast-off uniform, usually a misfit.

Discipline consisted of from one to three, or sometimes six or more months of hard labor. After being given their old, slovenly clothes, they were put at some menial work, such as shovelling coal, kitchen police, or sewer work, and were marched, followed and preceded by armed guards, through the streets of their companies and about the towns, attired in these dilapidated garments or in blue denim overalls, to distinguish them from other soldiers. They

were thus made a part of the so-called "prison gang," and treated as criminals, being kept under guard night and day; guards with loaded rifles stood over them while they worked and accompanied them wherever they went. They were ridiculed by other men, disgraced and degraded. They were put on short rations, often reduced to bread and water, as punishment for further misdeeds committed while under sentence. During their time of sentence they lost their drill practice and usually their calisthenics, and they were invariably quartered in close, ill-ventilated and often dark rooms or tents, with cots so close that their bodies almost touched one another. When they had completed their sentences and returned to their companies, they were shunnd and ridiculed by their companions and were down-and-out in their organizations, with the result that they were soon again absent without leave or repeated offences for which they had been convicted.

This was the condition in the Army of Occupation in Germany when I left it in the spring of 1919. It is the condition today in most of the army organizations.

In August, 1920, I visited the American Forces in Germany, and Colonel Peek, who had formerly been adjutant in the 76th Division, who is now "G-4" on General Allen's Staff in Coblenz, and with whom I had often discussed the treatment of delinquents as being inhumane and ineffective, informed me that he had now worked out a plan which was most successful. In November, 1919, he established a disciplinary barracks, about two and one-half miles from Coblenz, on a high platean overlooking the Rhine. I suggested and he agreed that this disciplinary barracks should hereafter be called the disciplinary school.

We drove out there and Colonel Peek ordered the men to be put thorugh their drill on the parade ground. I never saw finer set-up soldiers than the men of these three companies. They were immaculate in dress and person, and prompt in obeying the orders of their commanding officers. They stood in open ranks while we walked within a foot of each for inspection. They were so straight and immobile it was difficult to believe they were alive. Not an eye turned, and I could not see that a man even winked as we passed by—and these men had heretofore been considered the worst element in the Army, hopeless as to discipline, and not defective enough to be disqualified for service. The majority were men who had been sentenced for absence without leave, and the balance had been guilty of a long list of other delinquencies and crimes.

The physician who had examined them on entrance to this school considered that a large proportion of them were defective. Those whom he found actually feeble-minded, he returned to the States; but those who were classified as "morally defective," he felt should not be returned, as the treatment it was possible to give them there often made them into as good soldiers as there were in the Army.

Now let us follow the prisoner, defective or otherwise, as now handled by Lt.-Col. Peek in the American Forces in Germany:

Soldiers who are absent without leave are picked up all over France and Germany, and other delinquents of various kinds are arrested wherever they may be, and all are sent to their organizations for trial and sentence. All sentences of more than a few hours or a few days must be to the disciplinary school, where they are to serve their full time.

When the prisoner arrives at the school, usually with the oldest uniform the company has to give him—sometimes so flagrant a misfit that the tattered sleeves hang below his hands—he is at once sent to the tailor, where measurements are made for a new uniform. He is then made clean—virtually sterilized—and examined by the doctor, who makes a report as to his condition, mental and physical, including teeth, etc. A new uniform, without insignia, is then issued to him, together with a new and complete outfit, such as is prescribed for every soldier on active duty. This includes materials for keeping boots and gun in proper condition, besides his mess-kit, clothes and toilet articles—tooth brush and powder, hair brush, soap, towels, handkerchiefs, etc. He is given special instruction as to the care of his person, especially his teeth and feet. He is assigned to a light, well-ventilated dormitory, and instructed how to place each article that has been issued to him on his cot in the same position as the like article on every other cot, so that the inspecting officer can, at a glance, determine if any article is missing or in poor condition. In the morning, every bed is made up and the mattress turned half-way down on the bed, the various articles being arranged on this turned-over mattress.

He is then put at whatever work may be indicated as a result of his examination. The men who have been absent without leave are often in a run-down condition, poorly nourished and exhausted. They are given light duties, such as learning to take care of their guns, taking them apart and putting them together again, pressing and cleaning uniforms or other tailor work, or some practical mental training which will come into play in army life. Instead of being deprived of a portion of their rations, or put on limited rations, as many prisoners are, a diet is prescribed which builds them up.

As soon as the newly-arrived delinquent is in "condition," which is usually within a few days or a week, he is put under the regular disciplinary routine. This includes intensive drilling eight hours of every day of the week except two. Of these, one is Sunday, when there are only limited drills to go through; on the other day drilling is neglected only in the afternoon, when all take part in athletic games and sports. Calisthenic exercises are also given, and certain gymnastics from time to time. In the evenings there are recreations and amusements, such as moving pictures, music, etc. As no man is sent here for less than one month, even the shortest-term men are sure to get most valuable intensive training, and when they are returned to their companies, instead of being looked down upon, made butts of and socially shunned, they are among the best-dressed and best set-up men in their organizations, and are respected and often chosen to be drill masters and instructors.

This system has proved to be successful. The school was organized in November, 1919, and when I was there nine months later, 700 men, out of an organization of 15,000 soldiers, had passed through the school, with an average sentence of four months. Of these 700, only 20 had been returned. Those who have passed through often revisit the school, and are quite proud of what they have done there. On the Fourth of July, the men were told in the morning that the day was theirs to do as they pleased. There were to be games and athletics in Coblenz, which they were free to attend, but they must return by a certain hour in the afternoon. About 100 men were serving sentence at that time; all went off on that day and every one returned on time.

I have always held that the defective delinquent should be handled in an entirely different manner from the normal offender, and especially is this so in the case of women. Compare the above-described way of handling defective delinquents with the way defective delinquent women were treated in a Massachusetts prison only a few years ago,—and, for all I know, may still be treated. My attention was called by a former Governor to the fact that young women prisoners, because they would not work at the tasks assigned them or follow out the rules of the institution, which were not made applicable to these defectives, were "spread-eagled" on wire springs covered only with a blanket, tied hand and foot to the edges of the beds, and kept, according to the records, in some instances, 36 hours in this position. This punishment was intended to make the defective "give in." If she gave in, she was released at once; otherwise, not until exhausted. Another humane (?) mode of treatment as carried on in this prison was to lock these girls up like wild animals in special rooms (where they were fed by pushing in bowls of bread and milk or other light diet, through partly opened doors) until their spirit was broken, or until they had become docile and amenable to the will of those in whose power they were.

This class of defectives, neither insane nor feeble-minded, need special study and scientific care and treatment in order to bring out the best that is in them; such treatment as I have described is bound to call out their worst qualities. I have always advocated and do now urge a separate institution or school for the training of this class of persons, that they may be taken out of our prisons, out of our state hospitals and schools for the feeble-minded, and given over to the care of a staff of scientists and teachers, who will not attempt to handle them as a unit, but will study each individual and ascertain just wherein that individual is defective, and then classify them in groups of from one upwards, planning and prescribing the individual needs and treatment of each group, to the end that they may be made useful and at the same time be protected from the irritations and influences their environment brings about in institutions of the prison type above described. Evidently such conditions are also found in Bedford Reformatory, New York; in spite of the claims of this reformatory, as of our Massachusetts prison, of humane treatment

given women prisoners, there is quite a large class of defectives of whose needs they are apparently totally ignorant; at any rate, it would appear to be impossible for them to treat these difficult cases intelligently, scientifically and humanely. According to their own statements, they have, after all these years of experience in the care of delinquent girls, only arrived at the primitive method of treating defectives by coercion, punishment, and in some instances, actual cruelty, which they would not be permitted to inflict upon a dog or other animal.

As you all know, our hospitals for the mentally sick, presided over by educated and scientific physicians, would never think of treating these defective cases as they are treated in prisons and reformatories. I remember that, when I was a member of the State Board of Insanity, we sent a small group—three white and one colored—of what were supposed to be incorrigible, defective delinquent girls, who had been passed on from one institution to another, to the superintendent of ons of our state hospitals, with the request that they be specially studied, with a view to developing the best that was in them and of utilizing their tremendous superfluity of physical force with intelligence, which before had been misapplied and misdirected. At first, these girls went through the walls of their rooms as if they had been made of paper, and nearly killed one physician, and committed many delinquencies, moral and criminal, as well as flagrant breaches of discipline. After a month, I visited the hospital and found all happily at work and among the most efficient and best-behaved inmates of the hospital; and this had been accomplished without force or punishment. One, the superintendent told me at the end of the season, had canned more tomatoes than any other patient in the hospital; another was doing some extraordinarily good work on a sewing-machine; and the other two were also doing well, employed according to their personal needs.

Why can not investigation be made of what is being done with this class of offenders in institutions where occupational therapy is specially studied and scientifically applied, as in our Army in Germany, as well as in many of our schools for feebleminded? Then let us urge, as I have before, a school for this special class. I do not believe that there is one of these defectives who has not got some vulnerable point —something in him that will respond to the right care and treatment. But nothing can be gained and nothing has ever been gained by breaking their spirit or their will. They are an enormous expense to the community under present methods, and are continually passed from one institution to another, without receiving treatment of any permanent benefit to themselves, to the institutions, or to the community; and wherever they are, they hamper the work of the institution with the class of inmates for which it is designed.

Book Review.

Massage and Exercises Combined. By Albrecht Jensen. New York: Brooks & Potter. 1920.

In this volume, "Massage and Exercises Combined," the author has described a system of physical training whereby scientific massage movements may be combined with exercises for the development of the human body and physical health. The methods described are simple and may be carried out readily at home. The beneficial results which may be achieved by the application of scientific massage movements in stimulating the nerves, tissues, muscles, organs, vessels, glands, and cells have been found by the author to be much greater than those accomplished by means of general exercises, while he believes that from the balanced and logical combination of massage movements with exercises may be expected the best possible results, not only in the maintenance of health, but also for special therapeutic and physiologic purposes. No gymnastic equipment is required for carrying out the treatment prescribed in this book, and the exercises may be graduated according to individual need and strength. In one chapter are discussed methods of adapting these exercises to diseased and disordered conditions of the body. The author describes the bad effects often resulting from the use of heavy apparatus, weights, and exercises of too strenuous a nature, and explains the construction and characteristics of the combined massage exercises, illustrating them by plates.

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VACCINATION IN THE LEGISLATURE.

ON March 2nd, the Committee on Public Health of the Legislature will hold hearings on two bills dealing with vaccination. In the meantime it is hoped that the Supreme Court will have ruled on the question as to whether a physician's certificate that vaccination would be injurious to a child holds good year after year.

A bill (Senate 221) introduced by the Medical Liberty League provides that any child may attend the public schools, "who presents a written statement signed by a registered physician, parent or guardian, that he is of the opinion that his health will be endangered by vaccination."

The other bill (House 466) introduced by Dr. Alfred Worcester and Dr. George N. Lapham, the presidents of the State Medical Societies, extends the requirement of vaccination to children in private as well as in public schools, "except upon presentation of a certificate signed by a registered physician that the physician has, at the time of giving the certificate, personally examined the child and that he is of the opinion that the physical condition of the minor under fourteen years of age is such that his health will be endangered by vaccination. The said certificate shall state the reasons for the opinion of the physician who signs it, and shall be valid only for one year from the date thereof."

These bills need no further comment. The Medical Liberty League is active in promoting meetings to protest against vaccination. They have headquarters from which much literature is issued. They have advertised in the papers advising parents as to methods whereby their children need not be vaccinated.

Meanwhile it is incumbent on the Medical Profession to explain to the public and to the Legislators the dangers of allowing a large number of persons in any community to remain unvaccinated. A conflagration need not necessarily follow at once on the building of inflammable structures. But smallpox and fire are sure to rage sooner or later if the material is at hand for them to feed upon.

THE PHYSICAL TRAINING AND SCHOOL NURSES' BILLS.

LAST year the Physical Training bill was defeated. Reported favorably by a vote of 16 to 6 in the Committee on Public Health and on Education sitting jointly, it was unanimously reported adversely by the Senate Committee on Ways and Means, a report accepted in the Senate by a vote of 24 to 14.

The arguments against the bill last year were that it would lead to the teaching of birth control and sex hygiene, that it involved centralization of power, and that a requirement of physical training in public schools would automatically impose the same requirement upon private schools.

The bill (Senate 177) reads as follows:

Section 1. School committees of cities and towns or groups of towns shall, not later than September 1, 1922, provide systematic courses of physical training for all pupils in elementary and secondary schools, and may use school buildings and grounds after school hours for this purpose.

Section 2. The Department of Education shall provide courses in the conduct of physical training in the state normal schools and shall assist local school authorities in the promotion of physical training in the public schools and for this purpose may expend during the year 1921, a sum not exceeding one and one-half cents, and thereafter may annually expend a sum not to exceed three cents for each child between the ages of six and eighteen enrolled in the public schools during the preceding school year.

Section 3. The courses of physical training shall consist of organized play, games, indoor and outdoor sports and athletics and all forms of physical exercise appropriate to the age and physical condition of the pupil.

It is difficult to see any relation in this bill to either sex hygiene or birth control. Clauses in the bill of last year which provided for supervisors of physical training have this year been elimiuated. Thus centralization is avoided. As regards the extension of the requirements to private schools the law provides that "school committees shall approve a private school only when the instruction in all the studies required by law is in the English language, and when they are satisfied that such instruction equals in thoroughness and efficiency, and in the progress made therein the instruction in the public schools in the same city or town; but they shall not refuse to approve a private school on account of the religious teaching therein.

The arguments for physical training of children need no presentation here. The appeal which we must make is for a consideration of this bill on its merits. If this is done, the result is certain.

The School Nurses' bill (Senate 239) adds school nurses to the requirement for school physicians. It is as follows:

"The school committee shall appoint one or more school physicians and nurses, shall assign one of each to each public school within its jurisdiction, shall provide them with all proper facilities for the performance of their duties and shall assign one or more physicians to the examination of children who apply for health certificates required by section eighty-seven of chapter one hundred and forty-nine, but in cities where the medical inspection hereinafter prescribed is substantially provided by the board of health, said board shall appoint and assign the school physicians and school nurses."

Under this bill a group of towns might share the services of a school nurse.

Physicians familiar with the good which the school nurses have wrought in many cities and towns must judge for themselves of the merits of this bill. Both this bill and the physical training bill are advocated by the Joint Committee on State and National Legislation of the state medical societies.

THE PREVENTION OF MALARIA.

It may not generally be appreciated that malaria costs on an average 1,130,000 deaths and more than 100,000,000 cases of illness every year in India alone, and India is only one of a great number of nations which fall within the malarial zone. Malaria in mild form is distributed almost all over the known world; in its malignant form, "it belts the globe in a broad zone, including tropical and semi-tropical regions"; furthermore, more than half of the inhabitants of the earth live where infection is prevalent.

Until recently, the cost of adequate anti-malaria measures has been too great, except in cases where the elimination of malaria was an absolute necessity, to be accomplished regardless of expense, and in large cities where a dense population makes the per capita expense relatively light. A case of the former type was that of the Panama Canal Zone, where for five years, the annual per capita cost was $3.65. In Port Said, satisfactory malaria control was secured at an annual cost of 10 cents per capita; Port Said, however, has 100,000 inhabitants, a population large enough to bear a total expediture which would be prohibitive for towns of from 1,000 to 5,000 inhabitants.

Recent tests in Arkansas and Mississippi, however, have proved that malaria control is economically feasible in towns of 1,000. Four methods were tried: anti-mosquito measures, screening of houses, administration of quinine, and attacking the parasite in the blood of the human carrier. All of these methods gave excellent results. At Crossett, Arkansas, a lumber town of 2,129 inhabitants, where climatic conditions and abundant breeding places favor the propagation of anopheles, and where about 60% of all sickness was due to malaria, which was present in endemic form, the first experiment was tried. Pits and shallow ponds were filled or drained. Undergrowth was cleared

away from the edge of running streams, their banks were trimmed, and they were held to narrow channels, with, of course, a swifter current. Other places which could not be drained or filled were cleared of vegetation, opened so as to allow access to small fish (natural enemies of mosquitoes), and oiled weekly with road oil, either by means of automatic drips, or with a knapsack-type sprayer. All artificial containers were removed from the vicinity of the homes, and water barrels on bridges were treated with niter cake. The first result was the apparently almost complete elimination of the mosquito. The actual reduction in malaria, as shown by parasite indices from May to December, 1916, was 72.33%. In 1915, there had been at Crossett 2,500 calls for the services of the local physician in malaria cases. In 1916, there were but 741, a reduction of 70.36%.

Crossett was convinced of the value of anti-malaria measures. It took over the work of mosquito control, and in 1917, succeeded in reducing the number of doctors' calls to 200—less than one a day. In 1918, this was reduced still further, to 73. In three years, Crossett had eliminated 97.1% of its malaria.

The per capita cost of the work the first year was $1.24, omitting over-head expenses, which could not properly be charged against the campaign. The total cost for 1917 was 63 cents per capita; and in 1918 Crossett was kept virtually malaria-free at an expense of 53 cents for each inhabitant. Five other towns were similarly treated with virtually the same results.

The second method—screening houses—was tried in 1916 at a group of plantations along the shore of Chicot Lake, Arkansas. This section was infested with mosquitoes, and had a high malaria rate. A larger number of the houses were negro cabins, often poorly constructed and difficult to screen. Nevertheless, all of the openings in the house were covered with 16-mesh galvanized wire cloth. The tenants were also shown how to keep the screens in good condition, and were warned of the danger of exposure to mosquitoes outside, at night.

From May to December the reduction in malaria, based on the parasite-index method, was 70.6%. The average cost of screening each house was $14.59, and, as the screens easily last two years, the average annual cost was $7.30, and the cost per capita, $1.75.

In another group of plantations, which lay along a sluggish bayou where mosquitoes bred plentifully, the immunizing quinine method was tested. Each adult in the community was given 10 grains of quinine daily—five in the morning and five in the evening—for two successive days each week. For children under 15, the dose was one grain for each three years of their age. Parasite indices taken in May and December of the year 1916 showed a malaria reduction of 64.45 per cent., at a per capita cost of 57 cents.

The final method of malaria control is to destroy the parasites in the blood of the carriers. This was first suggested by Dr. Robert Koch, the famous German physician and discoverer of the tubercle bacillus, during a visit to Italy in 1898, and first demonstrated by him in Stephansport, German New Guinea, in 1900, where he materially reduced the malaria rate in this little town of 734 persons. During 1916 and 1917, this method was tested among more than 30,000 people in Bolivar County, Mississippi. Ten grains of quinine a day for eight weeks was found sufficient to sterilize the blood of about 90% of the persons to whom it was administered. In 1918, the test was applied to Sunflower County, Miss. "This area," says the report of the experiment, "like the delta region in the heart of which it lies, is level, low-lying, and covered at frequent intervals with a net-and-patchwork of sluggish streams, bayous and swamps . . . a typical rural area." About 9,000 people live in the 100 square miles selected for the demonstration: 1,000 in the town of Ruleville and 8,000 on the cotton plantations.

There are about four times as many negroes as white people in the test area. From one-third to three-fourths of the people on the plantations are estimated to have one or more attacks of malaria annually. Of an annual doctor's bill of $4,000 for one plantation with 600 tenants, $3,000 was chargeable to the one disease. A census was taken, showing that 40% of the rural population had had malaria within twelve months, and that, of the remaining 60%, 22% had the parasites in their blood. All persons who had had malaria and who were carrying parasites, were given 10 grains of quinine a day for eight weeks. It has been estimated by the directors of this work that approximately 80% control has been established over malaria.

These experiments point the way to action.

In South Georgia the American Red Cross has been conducting an intensive anti-malaria campaign, in coöperation with the State Board of Health, the Georgia Association, the U. S. Public Health Service and several large corporations. The tests have shown that where mosquito control is feasible, it unquestionably is practical. It is evident that it pays both in direct saving of money and in greater efficiency, to put into effect one or more of the anti-malaria measures. All that is needed is the willingness to be shown, and expert advice; the one must come from the people, but the other is to be had for the asking.

AMERICAN WELFARE WORK IN PARIS.

The model American "settlement house" established by the American Red Cross, in 1917, in the heart of the very poor districts in Paris, where the average child mortality has been between 30 and 40% for many years, has been making remarkable progress in its campaign against disease and death. Of 1127 nursing infants treated at the Red Cross foundation during a period of ten months, only 39 died. Under ordinary circumstances, probably, 394 of these children would have succumbed. The total mortality among the children cared for by the institution has been 3% as against 40% for the other children of the same district—the 19th Ward.

This settlement house has been adopted by the French as a model for the future organization of all "medico-social" service in France. A French society, headed by Madame Raymond Poincarè, has undertaken to supply the finances for the continuation of the work in Paris' poorest district, and, at the same time, to spread abroad the doctrines of social welfare as practised in America and exemplified in the work of the 19th Ward Social Center.

For the first time, France has seen, through this settlement house, a practical demonstration of American "medico-social" methods. Until the coming of the Red Cross foundation, the French social service worker and the public dispensary practitioner never met. There was no idea of combining home betterment and medical aid to achieve a common end of disease prevention. With the establishment of its American plan Social Center in Paris, the Red Cross has pointed the way to a new idea for France in public welfare organization which Frenchmen have not been long in appreciating and undertaking. Although the institution is now in the hands of a society of French philanthropists, it has retained throughout the methods initiated by its American organizers.

Exactly as in similar institutions in America, the Paris Social Center sends its visiting nurses out to educate the prospective mothers and sees that the mothers are properly attended during the confinement period; in addition, the organization makes itself a virtual guardian of the baby's health, keeping a record of each child's progess up to the age of 16 years, furnishing the mother with practical demonstrations of the essentials of child hygiene, providing medical attention in case of need, and, through its visiting nurses, observing conditions among families. For the ailing and backward children of the ward an American kindergarten has been installed.

Between the months of July, 1919, and May, 1920, the Social Center of the 19th Ward provided 462 medical clinics for its charges. These clinics were attended by 9,016 mothers and children. The institution's social workers and nurses made 16,160 home visits and inspections during this period.

MEDICAL NOTES.

British Honors to the Medical Profession.—Among the honors included in the New Year Honors List this year, the recognition of medical journalism by the conference of knighthood on the editors of the *Lancet*, and of the *British Medical Journal* is of particular interest, as this is the first instance in which medical journalism has been granted this distinction. Sir Dawson Williams, C.B.E., M.D., D.Sc., F.R.C.P., editor of the *British Medical Journal*, and Sir Squire Sprigge, M.A., M.D., editor of the *Lancet*, have received the honor of knighthood.

Appointment of Dr. Oscar Klotz.—Announcement has been made of the appointment of Dr. Oscar Klotz, Professor of Pathology in the University of Pittsburgh Medical School, as representative of the International Health Board of the Rockefeller Foundation for medical research work and education in São Paulo, Brazil, serving as director of a pathologic institute.

THE LETTSONIAN LECTURES.—The first of the Lettsonian Lectures before the Medical Society of London was delivered on February 7, 1921, by Mr. G. E. Gask. On February 21 and March 7, Mr. Gask will speak on "Surgery of the Lung and Pleura," the subject of the lectures this year.

BOSTON AND MASSACHUSETTS

WEEK'S DEATH RATE IN BOSTON.—During the week ending February 12, 1921, the number of deaths reported was 201 against 508 last year, with a rate of 13.84 against 32.77 last year. There were 23 deaths under one year of age against 68 last year.

The number of cases of principal reportable diseases were: Diphtheria, 74; whooping cough, 19; scarlet fever, 77; typhoid fever, 1; measles, 113; tuberculosis, 36.

Included in the above were the following cases of non-residents: Diphtheria, 7; scarlet fever, 2; typhoid fever, 1; measles, 14; tuberculosis, 7.

Total deaths from these diseases were: Diphtheria, 3; whooping cough, 3; scarlet fever, 1; tuberculosis, 19.

Included in the above were the following non-residents: Tuberculosis, 1. Encephalitis lethargica: cases, 8; death, 1.

BOSTON MEDICAL LIBRARY.—The annual meeting of the Boston Medical Library was held January 11, 1921. The officers of 1920 were re-elected and reports were received from the executive committee, the librarian and the treasurer. The Library now contains 106,892 books and 85,291 pamphlets and it has been used during the year 1920 by an increased number of readers while the halls and rooms have been occupied by 61 different society meetings, with a total attendance of 3,488. The collection of foreign books and periodicals is now very complete owing to the recent trip of the assistant librarian to Europe. The librarian showed some of the recent and more valuable accessions and the assistant librarian read a paper on "Some Personal Experiences on a Medical Book-buying Trip in Germany in the Spring of 1920."

THE next annual meeting of the Massachusetts Medical Society will be held in Boston, Tuesday, May 31, and Wednesday, June 1, 1921.

The Massachusetts Medical Society.

STATED MEETING OF THE COUNCIL.

FEBRUARY 2, 1921.

A STATED meeting of the Council was held in the Boston Medical Library, Wednesday, February 2, 1921, at 12 o'clock, noon. The President, Dr. Alfred Worcester, was in the chair and the following ninety-two councilors present:

BERKSHIRE,
A. P. Merrill.
BRISTOL NORTH,
W. O. Hewitt.
BRISTOL SOUTH,
W. A. Dolan.
ESSEX NORTH,
R. V. Baketel.
J. F. Burnham.
G. E. Kurth.
F. D. McAllister.
F. B. Pierce.
ESSEX SOUTH,
W. G. Phippen.
J. F. Donaldson.
H. K. Foster.
W. T. Hopkins.
J. F. Jordan.
G. M. Kline.
A. N. Sargent.
R. E. Stone.
FRANKLIN,
G. P. Twitchell.
HAMPDEN,
J. M. Birnie.
M. B. Hodskins.
MIDDLESEX EAST,
C. E. Ordway.
MIDDLESEX NORTH,
W. B. Jackson.
M. I. Tighe.
MIDDLESEX SOUTH,
H. T. Baldwin.
A. W. Dudley.
F. J. Goodridge.
F. R. Jouett.
E. H. Stevens.
John Duff.
Godfrey Ryder.
C. H. Staples.
C. E. Mongan.
G. W. W. Whiting.
C. A. Dennett.
W. E. Fernald.
Alfred Worcester.
F. R. Stubbs.
C. E. Hills.
G. A. Bancroft.
E. H. Bigelow.
A. K. Stone.
Fresenius Van Nüys.
NORFOLK,
D. N. Blakely.
F. L. Brearton.
NORFOLK (*cont.*)
E. H. Brigham.
A. N. Broughton.
W. L. Burrage.
H. T. Holland.
G. W. Kaan.
W. B. Keeler.
Bradford Kent.
M. V. Pierce.
Victor Safford.
G. H. Scott.
Augusta G. Williams.
NORFOLK SOUTH,
C. S. Adams.
Fred E. Jones.
PLYMOUTH,
W. C. Keith.
C. E. Lovell.
Gilman Osgood.
F. G. Wheatley.
SUFFOLK,
J. W. Bartol.
F. J. Cotton.
Loretta J. Cummins.
Lincoln Davis.
Channing Frothingham.
W. J. Gallivan
G. S. Hill.
W. C. Howe.
J. J. Minot.
W. H. Robey, Jr.
Stephen Rushmore.
C. L. Scudder.
C. M. Smith.
J. S. Stone.
Louisa P. Tingley.
F. H. Williams.
WORCESTER,
F. H. Baker.
W. P. Bowers.
W. J. Delahanty.
G. E. Emery.
M. F. Fallon.
Homer Gage
R. W. Green.
A. G. Hurd.
C. B. Stevens.
G. O. Ward.
F. H. Washburn.
S. B. Woodward.
WORCESTER NORTH,
W. E. Currier.
E. L. Fiske.
J. G. Henry.
W. F. Sawyer.

There being no corrections offered, the minutes of the last meeting were adopted by vote as printed in THE BOSTON MEDICAL AND SURGICAL JOURNAL. The Secretary stated that a volume of records of the Council, 1909-1920—the first loose-leaf book to be used—had been finished, and he offered it for inspection by the

Councilors. Dr. S. B. Woodward presented the report of the Committee on Membership and Finance as to Membership and it was voted to accept it and adopt its recommendations.

REPORT OF THE COMMITTEE ON MEMBERSHIP AND FINANCE, AS TO MEMBERSHIP.

The Committee on Membership and Finance makes the following recommendations as to membership:

1. That the following named Fellows be allowed to retire, under the provisions of Chapter I, Section 5, of the by-laws:

Wilfred Baxter Bancroft, 597 Broadway, South Boston.
George Danforth Bliss, 508 Washington St., Dorchester.
George Wells Brace, Westfield, Mass., with remission of dues for 1918, 1919 and 1920.
Charles Allen Davis, South Dennis.
John Arthur Tenney, 151 Huntington Ave., Boston.
Levi White, 11 Henshaw St., Worcester.
Arthur Bennett Morong, 12 Blackwood St., Boston.

2. That the following named Fellows be allowed to resign under the provisions of Chapter I, Section 7, of the by-laws:

Parker Burnham, 15 Western Ave., Gloucester.
Alphonso Holland Carvill, 28 Highland Ave., Somerville.
Albert Ulysses Franklin Clark, 690 Congress St., Portland, Maine.
Arthur Dixon, 28 Pleasant St., Worcester.
Arthur Brewster Emmons, 2nd, Dover.
Arthur Willard Fairbanks, 186 Temple St., West Roxbury, with remission of dues for 1920.
George Wells Fitz, 114 N. Clara Ave., Deland, Florida.
Charles William Galloupe, 374 Commonwealth Ave., Boston.
William Ellsworth MacPherson, Watertown Arsenal, Watertown.
Howard Osgood, 469 Franklin St., Buffalo, N. Y.
John Donald Proctor, 61 Winter St., Keene, N. H.
Thomas Melville Proctor, South St., Wrentham.
Frederick Stocker Raddin, 25 County Road, Chelsea.
Beatrice A. Reed Chatigny, 37 Standish St., Dorchester.
Myra D. Allen Ruppel, 4th Field Artillery, Camp Stanley, Texas.
Robert Bass Scales, The Claymoor, St. Petersburg, Florida.
Albert Atherton Taft, Keene, New Hampshire.
Hubert Granville Wilbur, Long Beach, California.
Melver Woody, College of Medicine Univ. of Tenn., Memphis, Tenn.
Dennis Francis O'Connor, Broad St., Newark, N. J.
Martin William Peek, Towson P. O., Md., with remission of dues.
Arthur Howard Wentworth, 77 Browne St., Brookline, as of January 1, 1920.

3. That the dues of the following Fellows for 1920 be remitted as they were still in the Service of the United States during a part, or the whole of that year:

Clarence Edward Burt, New Bedford.
Edward Richard Gookin, 799 Columbia Road, Dorchester.
James Joseph Regan, *U. S. S. Relief*, Navy Yard, Philadelphia.

4. That the following named Fellow be deprived of the privilege of membership, as provided by Chapter I, Section 8, of the by-laws:

William David Hilliard, Medical Bldg., Asheville, N. C.

5. That the following named Fellows be allowed to change their district membership without change of legal residence, under the provisions of Chapter III, Section 3, of the by-laws:

Frank William Marvin from Middlesex South to Suffolk.
Forrest Bertram Ames from Norfolk to Suffolk.
Harry Archibald Nissen from Norfolk to Suffolk.

Respectfully submitted,
SAMUEL B. WOODWARD,
Chairman, Committee on Membership and Finance.

Dr. Woodward read the estimate of the Committee of Arrangements as follows:

ESTIMATE OF COMMITTEE OF ARRANGEMENTS.

January 12, 1921.

Dr. Samuel B. Woodward,
Worcester, Mass.

Dear Dr. Woodward:

I am sending you a statement of the appropriation needed by my committee for the Annual Meeting of the Massachusetts Medical Society this year. I have been somewhat delayed in making up the estimate as the conditions of the dinner this year are so different from those of the last few years that it is difficult to estimate the proper number that will be present, but inasmuch, however, as I understand there will be no charge for the dinner, I am figuring on the basis of nine hundred to a thousand. Taking the latter figure, my estimate will be as follows:

A thousand dinners at $2.50 each....	$2,500
Cigars	280
Supper after the Shattuck Lecture ..	75
Printing dinner tickets, help, police, and other incidentals	100
	$2,955

Very truly yours,
CHARLES H. LAWRENCE,
Chairman, Committee of Arrangements.

The Secretary read the report of the committee appointed to consider the petition for restoration to the privileges of fellowship of Thomas Brinsley Foley, and it was voted to adopt the recommendations of the report that Dr. Foley be restored upon the carrying out of the conditions imposed. He read a petition from Fred Drew of Boston to be restored and the following committee was appointed by vote, on nomination by the chair, to consider it: E. G. Brackett, F. J. Cotton, E. B. Young. The chair announced the death on January 23, 1921, of Edward Henry Bushnell, of Quincy, Councilor and President of the Norfolk South District Medical Society, at the age of fifty-five.

The President nominated and the Council appointed the following delegates and alternates to the House of Delegates of the American Medical Association for terms of two years, from June 1, 1921:

Delegates	*Alternates*
F. B. Lund, Boston	W. H. Robey, Boston
E. F. Cody, New Bedford	F. W. Anthony, Haverhill

The following were appointed delegates to the annual meetings of State Medical Societies:

Maine: E. G. Hoitt, A. W. Dudley.
New Hampshire: G. E. Whitehill, J. A. Mehan.
Connecticut: E. A. Codman, J. L. Ames.
Rhode Island: W. A. Dolan, F. S. Churchill.

Dr. A. K. Stone read the report of the Auditing Committee, the Treasurer's report and financial statements by the Certified Public Accountant (See Appendix). On motion from the floor, duly seconded, it was *Voted*, That the reports be accepted and placed on file.

Dr. S. B. Woodward read the report of the Committee on Membership and Finance, as to finance with the Budget (See Appendix). He explained the provisions and called attention to the inconsistency of some of the standing committees paying mileage and others not paying the railway fares of their members. He pointed out that it was for the Council to decide as to the disposition of the estimated balance of $7,500 that would be left in the treasury, according to the Budget. On motion, duly seconded the report and the budget were adopted and ordered placed on file.

Dr. W. A. Dolan queried how long the Society would be required to pay the additional cost of THE BOSTON MEDICAL AND SURGICAL JOURNAL. Dr. Woodward replied that the Committee of Nine would report when they would be ready to take over the JOURNAL; they had recommended $15,000 as the amount of money they will require to manage the JOURNAL; that the original estimate was based on the estimated expense as given by the old proprietors.

The Chair stated that if the Council wanted to have the annual dinner without expense to the diners it would be necessary to appropriate $2,955, as estimated by the Committee of Arrangements, leaving $4,545 to be distributed to the District Medical Societies as a dividend; but that if every fellow who partook of the dinner was to pay for his meal, there would be more to distribute as a dividend. Dr. G. W. Kaan said that he was treasurer of the Norfolk District Medical Society and was interested to provide as good entertainments for his society as possible. This year they had asked the members of that district to subscribe an additional dollar to help pay the expenses of their meetings; the expenses of everything had increased and the cost of the six meetings of his district was excessive. He thought that other districts should have well attended meetings, and that the money of the Society was better expended for such uses, than for a dinner for the parent society in Boston that only a limited number would attend. He moved that the sum of $6,000 be appropriated as a dividend to the district societies and $1500 for the annual meeting. The motion was seconded. Dr. A. P. Merrill asked what the extra $1,000 would be saved for. He thought that this was a year when the districts would want that extra thousand and it would be preferable to appropriate it now rather than for another year when the prices would be lower. Dr. Kaan accepted Dr. Merrill's amendment and the motion as amended, namely that $7,000 from the estimated balance in the treasury, be appropriated as a dividend to the district medical societies, and $500 appropriated as a dividend from the same balance for the use of the Committee of Arrangements for the annual meeting, was put by the chair. Dr. Woodward warned the district societies that they could not expect to receive so large an amount in future years; that in the past the largest amount appropriated had been $4,500. Dr. J. M. Birnie said he spoke for the Hampden District Medical Society. His society wanted all the money it could get in order that a little lunch might be provided, especially for the members who came from Holyoke and Westfield; if the members could be kept together they could talk about the affairs of the Society and keep up interest also in the local organization. The chair thought that a dinner of the entire Society was an important factor in promoting sociability and coöperation; that this year the Committee of Arrangements had planned for a large mid-day dinner at the Copley-Plaza Hotel; that the district societies should be satisfied with a reasonable sum and not nearly twice what they had received in the past. There being no further discussion, the motion as amended was put, seconded and carried.

Dr. J. S. Stone read the following report of the Committee of Nine:

REPORT OF THE COMMITTEE OF NINE.

The Committee has unanimously chosen Dr. Walter P. Bowers of Clinton to be the Managing Editor of the BOSTON MEDICAL AND SURGICAL JOURNAL, as soon as it is taken over by the Society.

Negotiations for the transfer of the BOSTON MEDICAL AND SURGICAL JOURNAL to the Society are under way and as soon as certain legal technicalities are complied with the transfer will be made, probably within a fortnight.

The counsel of the Committee of Nine advised specific authorization in the charter of the Society f the publication of a journal, in order that there might never be any question of the legality of this action. A bill was therefore introduced in the House of Representatives on petition of Alfred Worcester, Homer Gage, S. B. Woodward, George W. Gay, and Walter P. Bowers, seeking an enlargement of the powers of the Massachusetts Medical Society, specifically allowing it to publish a journal. This action had to be taken before January 15th, if it was to come before the present session of the Legislature. As such requests should properly originate with the Society rather than with any officers of the Society, the Committee requests approval of the action of the petitioners and a formal vote requesting of the Legislature the passage of House Bill No. 1121, enlarging the powers of the Massachusetts Medical Society and authorizing the publication of a journal.

JAMES S. STONE, *Secretary.*

House Bill No. 1124.

Bill to enlarge the powers of the Massachusetts Medical Society.

Section 1. The Massachusetts Medical Society is authorized to engage in the publication and distribution of a journal or periodical to be devoted mainly to medical and surgical science.

Section 2. This act shall take effect upon its passage.

The foregoing bill has been filed with the Clerk of the House on the petition of Alfred Worcester and others.

Voted, To accept the report.

Dr. J. S. Stone *moved,* That the Council approve the action of Alfred Worcester, President of the Massachusetts Medical Society, and others, in petitioning the Legislature to enlarge the powers of the Massachusetts Medical Society under its charter, and authorize it to publish a journal, and directs the Joint Committee on State and National Legislation to favor the enactment of House Bill No. 1124, which provides this authority. The motion being seconded, was passed unanimously.

Dr. Homer Gage said that the preliminary report of his Committee of Nine had been presented to the Council last October; that the committee had held many meetings, one of them being with the presidents of the district societies so that the committee might have the advice of these officers before taking over the Journal. After deciding to take it over, the hitch had been the difficulty of finding somebody who thought he could manage the Journal to the satisfaction of the Society and they had finally made up their minds that if there was any man who could do it, that man was Dr. Bowers. They did not know whether he could take up the new task in addition to his duties at the State House. He finally yielded to the committee because he felt it was his duty, and the committee feel that it is a very fortunate outcome that the Journal will start out under very satisfactory auspices, and we predict that it will be successful.

Dr. A. K. Stone presented the report of the committee appointed at the last meeting to examine the papers of the Society in the vault at the building of the Boston Medical Library:

Report of the Committee on Papers in the Vault.

We would respectfully report that each member of the committee spent some time looking over the papers belonging to his department. Subsequently the whole committee met and unanimously voted the destruction of certain papers belonging to the Society, which, in their judgment, were deemed of no value, and they rearranged the remaining papers. The Librarian saw to the destruction of the worthless ones at a later time.

By this action the number of documents in the vault of the Library is materially reduced and there is room in the chests belonging to the Society to care comfortably for the records which are of value and the material which will necessarily collect from year to year until a similar committee is again appointed.

A. K. Stone,
W. L. Burrage,
E. H. Brigham.

The report was accepted and placed on file.

Dr. E. H. Bigelow reported on Maternity Benefits for the standing committee of the Society, on Public Health. He said he considered the bill a public health measure, that his committee had had a meeting on January 31, 1921, at which it was voted to endorse the principles contained in the bill on Maternity Benefits filed with the Legislature by the State Commission on Maternity Benefits. He moved the adoption of that vote by the Council. Dr. Bowers seconded the motion saying that he believed that the Councilors of the Massachusetts Medical Society should stand up in a body and uphold the efforts of the president of that society as chairman of the commission to improve the obstetric situation in the State; few realized the amount of time that had been expended in the duties of the office; the Governor had honored the Society in appointing its president to the position and the State was honored in the service that had been given; it was a very important matter and he hoped the motion would prevail. The motion was favored by Dr. E. L. Fiske and by Dr. Woodward, and opposed by Dr. Dolan on behalf of the Bristol South District and by Dr. Mongan. After a lengthy discussion in which portions of the bill as presented by the Commission, were read and commented on by Dr. Bowers, following allegations by Dr. Dolan that the bill was paternalistic, communistic and socialistic, Dr. Dolan moved that the motion be laid on the table, and it was so voted by a two-thirds majority, in a show of hands.

Dr. J. S. Stone said that the Commission on Maternity Benefits had issued a challenge to the medical profession. They have stated that approximately forty per cent. of deaths of mothers every year are preventable. They have stated that approximately forty per cent. of deaths in early infancy are preventable. They have stated that this problem is medical and not social. In view of these statements he introduced the following motion:

Moved: That a committee of seven be appointed by the President for the purpose of studying any measures for Maternity and Infant Welfare and to take such action and make such recommendations to District Societies, to the Council and in the columns of the Boston Medical and Surgical Journal as may from time to time be approved; said Committee being authorized to add to its membership, representatives of the Homeopathic Medical Society, and being directed to present a report of its actions and recommendations at the next regular meeting of the Council.

After the motion had been discussed and amended as regards where recommendations should be made, it was passed as printed:

The President appointed the following committee:

J. S. Stone, Boston.
C. E. Mongan, Somerville.
Richard Dutton, Wakefield.
W. P. Bowers, Clinton.
Thomas Almy, Fall River.
Brace W. Paddock, Pittsfield.
R. L. DeNormandie, Boston.

Dr. Dolan moved that the Secretary make known to the committee of the Legislature having charge of the bill introduced by the Commission on Maternity Benefits, the action of the Council in laying on the table Dr. Bigelow's motion to approve the principles embodied in that bill. The motion being seconded was put to a vote and lost.

Dr. J. S. Stone said that he would like to speak of a vote taken at a recent meeting of the joint committees of the Massachusetts Medical Society and Massachusetts Homeopathic Medical Society on State and National Legislation to the effect that the Secretary of the Massachusetts Medical Society be asked to notify the secretaries of the district medical societies that the joint committee was in favor of setting aside one meeting of each district society every year for the consideration of legislation, preferably the meeting in the month of February. No action was asked.

Dr. G. O. Ward offered the following preamble and resolution:

Whereas, it seems unwise that there should exist any discrepancy between the statutes of the Commonwealth of Massachusetts pertaining to the Massachusetts Medical Society and the By-Laws of said Society by which the election of officers is ordered. Therefore be it

Resolved, that Chapter IV, Section 3, of the By-Laws be so amended that the last sentence of paragraph one shall read: "Councilors only, shall be eligible to the offices above named," *viz.,* president, vice-president, secretary, treasurer and librarian, thus conforming the By-Laws to the Statutes, 1803, Chapter 85, Section 3. Digest, Article V, paragraph 3, which provides that the Councilors shall "appoint, from among themselves, a president, and such other officers of the said corporation as are to be so appointed."

It was moved and seconded that the amendment be approved, and it was so voted.

Dr. Ward offered the following amendment to Chapter I, Section 2, of the By-Laws: After the words "fiscal year," line two, insert in parenthesis marks "except as hereafter provided in Section 6 of this chapter."; also Chapter I, Section 6. The last sentence of paragraph one shall read: "The assessment paid by fellows who are admitted to the society following the November examinations, shall be that fixed for the next succeeding fiscal year, and shall cover the dues both for the current year and for the next fiscal year."

These two amendments were approved by vote.

The president nominated and the Council appointed Dr. M. B. Hodskins, of Palmer, a member of the committee to coöperate with the Massachusetts Federation of Teachers *vice* Dr. Annie Lee Hamilton, resigned.

Dr. Woodward called attention to the terms of Article X of the Digest of the Society, which provide that the Society may hold any property that it may receive, in value not exceeding the sum of two hundred pounds and the annual income or interest of such property shall not exceed the sum of six hundred pounds; "all the sums mentioned in this act (St. 1781, Ch. 15, Sec. 9) to be valued in silver at six shillings and eight pence per ounce." If the pound be considered at the present rate of exchange, the Society is getting more income than it is entitled to. He thought that the act referred to the Massachusetts pound, which was worth $3.33 1/3. He would like to have the attention of the Committee on State and National Legislation called to this matter, because if the Society should receive a large bequest it might not be authorized to take the income from it. He moved and it was voted that the matter be referred to the Committee on State and National Legislation.

Dr. Woodward called attention to a vote of the Council of June 5, 1828, nearly one hundred years ago, with reference to the Permanent Fund of the Society. The Society had received in 1810 a gift from the Commonwealth of a township of land in the District of Maine, six miles square, because, as it was said, the Society had incurred expenses and devoted a considerable portion of time to the "promotion of the laudable objects of their institution." This township was sold in 1823 and formed the basis of the Permanent Fund. The vote of June 5, 1828, was as follows: "That the Treasurer be directed to pay to the Massachusetts Hospital Life Insurance Company, in trust for the Massachusetts Medical Society, all monies which he may now hold, or may hereafter receive, belonging to the permanent fund of said society; the same to accumulate at compound interest, and to be subject to withdrawal at the most frequent periods allowed by the rules of said company, upon a regularly certified vote of the Counsellors of said society." He moved and it was *Voted,* That the above vote of June 5, 1828, be and it is hereby rescinded.

Adjourned at 1.40 P.M.

WALTER L. BURRAGE, *Secretary.*

APPENDIX.

REPORT OF AUDITING COMMITTEE.

To the President and Councilors:

We have examined the securities of the Society in the custody of the Treasurer in the vaults of the Bay State Branch of the Old Colony Trust Company; we find them in accordance with the Treasurer's schedule of investments.

The report of audit of the Treasurer's accounts by Horace C. Hartshorn, Certified Public Accountant, for the year ending December 31, 1920, we have also examined and accepted, and submit it herewith as a part of our report.

C. J. McCORMICK,
CHARLES M. GREEN,
Auditors.

Boston, January 18, 1921.

DR. C. J. McCORMICK, DR. CHARLES M. GREEN,
Audit Committee, Massachusetts Medical Society,
Boston, Mass.

Gentlemen:

In accordance with your instructions I have audited the books and accounts of your Treasurer, Dr. Arthur K. Stone, for the year ending December 31, 1920, and enclose herewith,

Schedule A Statement showing the Assets and Liabilities of the Massachusetts Medical Society, December 31, 1920.

Schedule B Statement showing the Profit and Loss Account of the Massachusetts Medical Society for the year ending December 31, 1920.

The cash on deposit with the banks has been reconciled with the bank statement and found to be correct. Disbursements have been verified, postings to the ledger checked, and trial balance found to be in balance. I have not examined the securities in the safe deposit vaults of the Society.

Respectfully submitted,
HORACE C. HARTSHORN,
Certified Public Accountant.

TREASURER'S REPORT.

SHOWING THE ASSETS AND LIABILITIES OF THE
MASSACHUSETTS MEDICAL SOCIETY
DECEMBER 31, 1920

Schedule A.

ASSETS.

Cash:		
New England Trust Co.	$2,689.98	
Old Colony Trust Co.	3,365.11	$6,055.09
Investments:		
Shattuck Fund		
Annuity Policy Mass. Hospital Life Ins. Co.	9,166.87	
Phillips Fund		
Mass. 3½% Gold Bonds .	10,000.00	
Cotting Fund		
Deposit in Institution for Savings in Roxbury and Vicinity	1,000.00	
Deposit in Provident Institution for Savings in the Town of Boston	1,000.00	
Deposit in Suffolk Savings Bank for Seamen and Others, Boston	1,000.00	
Permanent Fund		
Annuity Policy Mass. Hospital Life Ins. Co.	11,253.30	
Mass. 3½% Gold Bonds .	6,000.00	
Deposit in Franklin Savings Bank of the City of Boston	1,074.48	
Liberty Bonds		
Fourth Issue 4¼% due Oct. 15, 1938—Par value $5,200	5,043.23	$45,537.88
Cost $5,000.00 1st 3½% Bonds sold for $4,603.75 but showing on the books at $5,000.00		
Cash in addition 43.23		
Total $5,043.23		
Total		$51,592.97

LIABILITIES.

Endowment Funds:		
Shattuck Fund (G. C. Shattuck, 1854, Balance, 1866)	$9,166.87	
Phillips Fund (Jonathan Phillips, 1860)	10,000.00	
Cotting Fund (B. E. Cotting, $1,000.00, 1876, 1881, 1887)..	3,000.00	$22,166.87
Surplus:		
Balance, January 1, 1920 ..	26,862.23	
Year ending December 31, 1920 *Schedule B*	2,563.87	29,426.10
Total		$51,592.97

STATEMENT SHOWING THE CURRENT INCOME OF THE MASSACHUSETTS MEDICAL SOCIETY FOR THE YEAR ENDING DECEMBER 31, 1920.

Schedule B.

CREDIT.

Assessments paid to District Treasurers:		
Barnstable	$178.00	
Berkshire	526.00	
Bristol North	348.00	
Bristol South	783.68	
Essex North	1,087.00	
Essex South	1,240.00	
Franklin	215.40	
Hampden	1,271.50	
Hampshire	348.00	
Middlesex East	414.00	
Middlesex North	504.00	
Middlesex South	3,107.00	
Norfolk	2,880.00	
Norfolk South	345.20	
Plymouth	558.00	
Suffolk	4,297.00	
Worcester	1,641.00	
Worcester North	458.00	$20,201.78
Assessments paid to Treasurer		1,653.10
Contribution of Homeopathic Medical Society to Committee on State and National Legislation		80.00
Income Shattuck Fund		412.51
Income Phillips Fund		
Mass. 3½% Gold Bonds		350.00
Income Cotting Fund		
Interest—Institution for Savings in Roxbury and Vicinity	42.50	
Interest—The Provident Institution for Savings	45.00	
Interest—Suffolk Savings Bank	42.50	130.00
Income Permanent Fund		
Annuity Policy Mass. Hospital Life Ins. Co.	506.40	
Massachusetts 3½% Bonds	210.00	
Interest—Franklin Savings Bank	48.32	
Liberty Bonds	145.83	910.55
Income from Deposits in Banks		
New England Trust Co.	179.02	
Old Colony Trust Co.	90.57	269.59
Total		$24,007.53

DEBIT.

General Expense			
President's Expense	$100.00		
Secretary's Expense	1,169.54		
Treasurer's Expense	89.65		
Librarian's Expense	67.24		
District Treasurers' Expense	1,228.75		
Supervisors' Expense	26.69		
Censors' Expense	844.25		
Rent	750.00		
Salaries	2,000.00		
Delegates' Expense	500.00		
Bank Charges	1.72	6,777.84	
Boston Medical and Surgical Journal Guarantee		9,756.50	
Shattuck Lecture		200.00	
Committee Expense			
Arrangements	498.32		
Ethics and Discipline	5.60		
Medical Education and Medical Diplomas	138.20		
Membership and Finance	7.16		
State and National Legislation	375.12		
Public Health	643.87		
Health Insurance	13.70	1,681.97	
Annual Dividends to District Societies		2,000.00	
Defense of Malpractice Suits		685.02	
Cotting Lunches		342.33	$21,443.66
Balance to Surplus			$2,563.87

Respectfully submitted,
ARTHUR K. STONE, *Treasurer.*

RECONCILIATION BETWEEN THE PROFIT AND LOSS AND BUDGET FOR THE YEAR ENDING DECEMBER 31, 1920.

	PROFIT AND LOSS ACCOUNT	BUDGET ESTIMATE	DIFFERENCE Under Estimated	DIFFERENCE Over Estimated
Revenue:				
Assessments	$21,854.88			
Investments	2,072.65			
Total Society Revenue	$23,927.53	$22,600.00	$1,327.53	
Contribution by Homeopathic Society to Com. on State and National Legislation	80.00		80.00	
Increase in Revenue over Budget		1,407.53	$1,407.53	
Total as per Auditor's Report	$24,007.53	$24,007.53		
Expenses:				
Salaries of Officers	$2,000.00	$2,000.00		
Expenses of Officers:				
President	100.00	100.00		
Secretary	By-laws 1,169.54	350.00 / 750.00	69.54	
Treasurer	89.65	200.00		110.35
Librarian	67.24	50.00	17.24	
District Treasurers	1,228.75	1,200.00	28.75	
Supervisors	26.69	30.00		3.31
Censors	844.25	300.00	544.25	
Delegates	500.00	300.00	200.00	
Rent	750.00	750.00		
Boston Medical and Surgical Journal	9,756.50	10,500.00		743.50
Defense of Malpractice	685.02	600.00	85.02	
Shattuck Lecture	200.00	200.00		
Cotting Lunches	342.33	400.00		57.67
Standing Committees:				
Membership and Finance	7.16	5.00	2.16	
Ethics and Discipline	5.60	25.00		19.40
Medical Education and Medical Diplomas	138.20	250.00		111.80
State and National Legislation	375.12	720.00		344.88
Public Health	643.87	700.00		56.13
Special Committees:				
Industrial Insurance	13.70	50.00		36.30
Contingent Expenses	1.72	620.00		618.28
Dividends to Societies	2,000.00	2,500.00		1.68
Committee of Arrangements	498.32			
Total Expenses as per Auditing Report	$21,443.66		$946.96	$2,103.30
Total Budget		$22,600.00		
Expenses over-estimated	1,156.34		1,156.34	
	$22,600.00	$22,600.00	$2,103.30	$2,103.30
Revenue under-estimated	$1,407.53			
Expenses over-estimated	1,156.34			
Total Gain over Budget	$2,563.87			

REPORT OF COMMITTEE ON MEMBERSHIP AND FINANCE, AS TO FINANCE.

The Committee on Membership and Finance submits the following Budget for the fiscal year 1921.

It calls the attention of the Council to the fact that the object of a budget is to apportion as fairly as may be, the income of the Society to the various committees which must expend it; that this income is not fixed and can be only estimated; that certain committees are yearly allowed sums which they never spend, and that other committees are occasionally forced to exceed their appropriations.

They would also call attention to the gratifying fact that the actual income of the Society last year exceeded the estimate by $1,407.53, while the expenses were again overestimated by $1,156.34, resulting in a total gain to the Society over the budget, of $2,563.87, and that the present committee will be pleased if their forecast proves as satisfactory as did that of their predecessors.

Respectfully submitted,

S. B. WOODWARD,

Chairman, Committee on Membership and Finance.

THE BUDGET FOR 1921.

Income as estimated by the Treasurer			$32,000
Appropriations for expenditures:			
Salaries of officers:			
Secretary	$1,100		
Treasurer	500		
Librarian	400		
		$2,000	
Expenses of officers:			
President	$200		
Secretary	800		
Treasurer	150		
Librarian	50		
District Treasurers	1,500		
Censors	500		
Supervisors	30		
Delegates to A. M. A.	..		
		$3,230	
			$5,230
Rent			750
Journal			15,000
Defense Malpractice Suits			600

Shattuck Lecture	200	
Cotting Lunches	400	
Standing Committees		
Membership and Finance	5	
Scientific Papers	100	
Ethics and Discipline	25	
Medical Education and Medical Diplomas	225	
State and National Legislation	500	
Public Health	700	
Industrial Insurance	50	
Contingent Fund	715	
		$24,500
Unappropriated Balance		$7,500

Miscellany.

UNITED STATES CIVIL SERVICE EXAMINATIONS.

SENIOR ASSISTANT PHYSICIAN, $2,500 TO $3,500 A YEAR.
ASSISTANT PHYSICIAN, $2,000 TO $2,500 A YEAR.
JUNIOR ASSISTANT PHYSICIAN, $1,500 TO $1,800 A YEAR.
Receipt of Applications to Close March 22, 1921.

The United States Civil Service Commission announces open competitive examinations for the positions listed above. Vacancies in Saint Elizabeths Hospital, Washington, D. C., at the salaries indicated, and in positions requiring similar qualifications, at these or higher or lower salaries, will be filled from these examinations, unless it is found in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

Range in salary.—The entrance salary within the range stated for each position will depend upon the qualifications of the appointee as shown in the examination.

Maintenance.—Maintenance is also provided to appointees, or in lieu of maintenance, an allowance which is determined by the amount of basic salary, either of which will be allowed in the discretion of the appointing officer.

Bonus.—Appointees at annual compensation of $2,500 or less, whose services are satisfactory, may be allowed the increase granted by Congress of $20 a month.

Citizenship and sex.—All citizens of the United States who meet the requirements, both men and women, may enter these examinations; appointing officers, however, have the legal right to specify the sex desired in requesting certification of eligibles.

Subjects and weights.—Competitors will not be required to report for examination at any place, but will be rated on the following subjects, which will have the relative weights indicated: (1) Education, 25; (2) Experience, 50; (3) Thesis, reports, or publications (to be filed with application), 25; Total, 100.

Basis of ratings.—Under the first two subjects the ratings will be based upon competitors' sworn statements in their applications and upon corroborative evidence.

Education.—For each of these positions applicants must have graduated from a recognized medical school.

Experience.—Under the second subject applicants for the position of senior assistant physician must have had at least five years' experience in an institution for the care of the insane or in genuine specializing work with the insane or allied classes; applicants for the position of assistant physician must have had at least three years of such experience; and applicants for the position of junior assistant physician must have had at least one year of such experience.

Writings.—Under the third subject applicants must submit with their applications, publications, or reports of which they are the author or co-author, or in lieu thereof, a thesis of at least 2,000 and not more than 5,000 words on some phases of insanity or allied conditions (feeble-mindedness, epilepsy, constitutional defectives, etc.)

The writing submitted must be such as may be retained on file with the application during the period of eligibility.

Age.—Applicants must not have reached their seventieth birthday on the date of examination. In view of the retirement act, should the appointing officer so requests, certification will not be made of eligibles who have reached their fifty-fifth birthday.

Retirement.—Classified employees who have reached the retirement age and have served fifteen years are entitled to retirement with an annuity. The retirement age for railway mail clerks is 62 years, for mechanics and post-office clerks and carriers 65 years, and for others 70 years. A deduction of 2½ per cent. is made from the monthly salary to provide for this annuity, which will be returned to persons leaving the service before retirement with 4 per cent. interest compounded annually.

Applications should be properly executed, excluding the county officer's certificate, but *including the medical certificate*, and must be filed with the Civil Service Commission, Washington, D. C., with the material required, prior to the hour of closing business on March 22, 1921.

SOCIETY NOTICES.

HARVARD MEDICAL SOCIETY.—Next meeting in the Peter Bent Brigham Hospital Amphitheatre (Van Dyke Street entrance), Tuesday evening, March 1, at 8.15 o'clock.

PROGRAM.

Kidney Function. By Dr. A. N. Richards, Professor of Pharmacology, University of Pennsylvania.

Medical students and physicians are cordially invited to attend.

CYRUS C. STURGIS, *Secretary.*

MASSACHUSETTS GENERAL HOSPITAL.—Staff Clinical Meeting, Lower Out-Patient Amphitheatre, Monday, February 28, 1921, 8 P.M.

PROGRAM.

1. The Pernicious Anemia of Pregnancy.
   Dr. George R. Minot.
2. Hemocidal Properties of the Blood.
   Dr. Thomas E. Buckman.
3. Some Aspects of Bile Pigment Metabolism.
   Dr. Chester M. Jones.
4. Isoagglutinins and Hemolysins In Infants.
   Dr. Basil Jones.

Doctors, nurses and medical students are invited.

F. A. WASHBURN, M.D., *Resident Physician.*

RECENT DEATH.

DR. EUDORA MEADE FAXON died at the home of her daughter, Dr. Dora W. Faxon, Arlington Heights, February 10, 1921, aged 78.

She was born in Waterville, Me., August 30, 1842, the daughter of Alonzo Draper, a Boston musician, and Hannah Vose Crane Draper. The family lived in South Boston, where Eudora was educated. In 1892 she was graduated from the College of Physicians and Surgeons of Boston, and in 1894, from the Tufts College Medical School. She joined the Massachusetts Medical Society in 1892 and was retired in 1912, practising in Boston and Franklin. Formerly she was active in the affairs of the Ladies Physiological Society. She married Henry Faxon, Jr., in 1865. He died in 1893.

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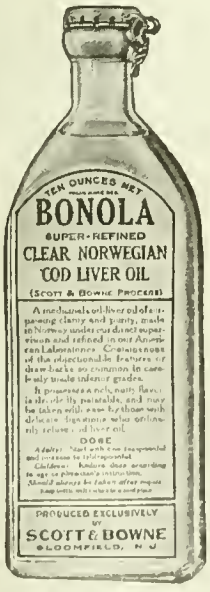

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Wrentham, Mass. 1-tf,B369

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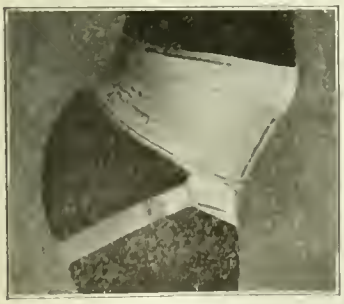

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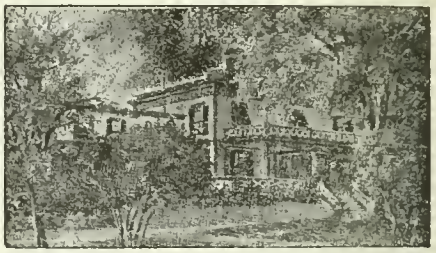

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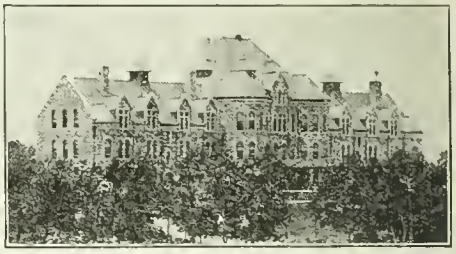

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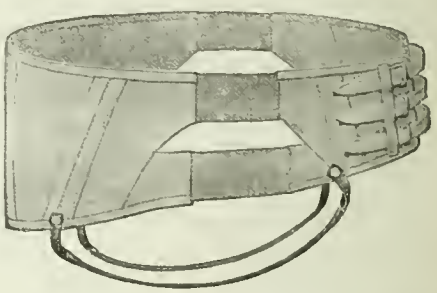

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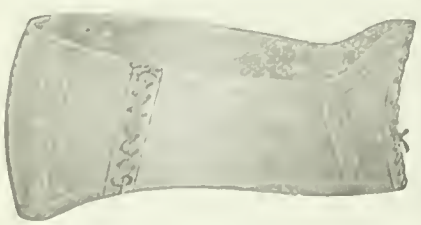

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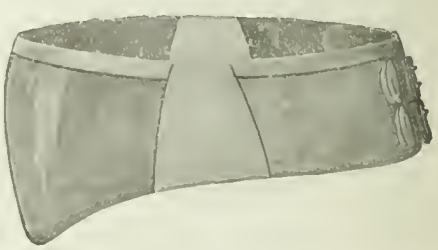

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